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 OF AMERICA'S HEALTH INSURANCE PLANS, THE AMERICAN BENEFITS COUNCIL, AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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America's Health Insurance Plans, the American Benefits Council, and the Chamber of Commerce of the United States of America respectfully submit this brief as *amici curiae* in support of petitioners, with the written consent of the parties.[1]

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[1] Letters of consent have been filed with the Clerk. No party or counsel for a party to this case authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person or entity other than *amici curiae*, their mem-

INTERESTS OF *AMICI CURIAE*

America's Health Insurance Plans ("AHIP") is the national association representing nearly 1,300 member companies that collectively provide health insurance coverage to more than 200 million Americans. The vast majority of individuals insured by AHIP members are participants in, or beneficiaries of, employee benefit plans under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*. The association's goal is to provide a unified voice for the health care financing industry, to expand access to high quality, cost-effective health care to all Americans, and to ensure Americans' financial security through robust insurance markets, product flexibility and innovation, and an abundance of consumer choice.

The American Benefits Council ("ABC") is a broad-based nonprofit trade association founded to protect and foster the growth of this Nation's effective and important privately sponsored employee benefit plans under ERISA. The members of ABC include both small and large employer sponsors of employee benefit plans, as well as plan support organizations, such as consulting and actuarial firms, investment firms, banks, insurers and other professional benefit organizations. Collectively, its more than 250 members sponsor, administer or advise plans covering more than 100 million plan participants.

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bers, or their counsel has made a monetary contribution to the preparation or submission of this brief.

The Chamber of Commerce of the United States of America ("the Chamber") is the world's largest business federation, representing an underlying membership of over three million businesses and organizations of every size, in every industry sector, and from every geographic region of the country. A principal function of the Chamber is to represent the interests of its members by filing amicus briefs in cases involving issues of vital concern to the nation's business community. Many Chamber members provide health benefits to employees and arrange for the provision of health care services through employee welfare benefit plans regulated under ERISA. The ability of its members to purchase affordable health care coverage for the benefit of their employees is of vital importance to them, their employees, and the employees' dependents, and to the Chamber.

INTRODUCTION AND SUMMARY

For more than 30 years, ERISA's system of uniform regulation for employee benefit plans has fostered the development of widespread employment-based coverage for disability, health, and other benefits. ERISA does not require that employers adopt benefit plans, nor does it mandate any particular terms. Plan design is a "settlor" function, subject to the discretion of the employer who sponsors the plan. One critical component of plan design is the authority of the plan fiduciary responsible for administering the plan and determining eligibility for benefits. As this Court recognized in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), employers may – and in amici's experience, generally do – confer on plan fiduciaries full discretion to administer the plan and make plan benefit determinations.

And ERISA expressly contemplates that employers may confer that discretion on an entity that is also the source of funding for the plan. *See* 29 U.S.C. § 1108(c)(3). For insured plans, a single entity can reduce administrative expenses by serving as both insurer and plan fiduciary. For self-funded plans, the employer itself or an internal benefits committee can serve as fiduciary without the need to contract with a third party. Because of these efficiencies, it is common for employer-sponsored benefit plans to utilize a single entity to perform fiduciary (claims administration) and non-fiduciary (insurance) functions.

The regulatory framework established by ERISA – including its provision allowing a single entity to perform both fiduciary and non-fiduciary functions – has functioned effectively. The competitive market for group insurance prevents insurers who perform claims administration functions from systematically denying claims for benefits. Not surprisingly, the overwhelming majority of benefits claims are approved. And for claims that are initially denied, Department of Labor regulations guarantee each claimant a right to a full and fair internal review, providing further protection for beneficiaries. For insured health-benefit plans, most states accord beneficiaries a right of appeal to an independent medical reviewer. These market pressures and regulatory constraints all operate to ensure that fiduciary claim determinations are not driven by improper considerations, but are made, as they must be, with an eye toward the best interests of the plan as a whole.

For those reasons, the fact that one entity – either an insurer or the employer itself – separately performs both fiduciary and non-fiduciary functions should not trigger heightened judicial review of claim determinations. Where the plan specifies that a fiduciary's claim determination is discretionary, *de novo* or "sliding-scale" review by courts would frustrate ERISA's purpose to achieve uniformity of interpretation, as illustrated by the splintered approaches of courts of appeals on the questions presented in this case. A plan sponsor can reasonably decide that an experienced and qualified fiduciary will be better positioned than a court to evaluate benefits claims consistently and uniformly in the best interests of the plan as a whole and the rest of its participants. Departing from the abuse-of-discretion standard would have adverse consequences for benefit plans by increasing litigation costs and leaving less money available to pay out claims.

Consistent with principles of trust law relied upon by this Court in *Firestone*, a determination by any fiduciary should be reviewed deferentially unless the evidence establishes that the decision was actually infected by an improper consideration, *i.e.*, the fiduciary's own interest rather than the plan's. A claimant could make such a showing by pointing to evidence of bias or corruption on the face of the administrative record. If the claimant demonstrates that an improper motive actually factored into the fiduciary's determination, then the court should conduct an ordinary trust law analysis by weighing that conflict alongside other factors in assessing whether the fiduciary abused its discretion.

ARGUMENT

I. ERISA'S FRAMEWORK PERMITTING A SINGLE ENTITY TO PERFORM FIDUCIARY AND NON-FIDUCIARY FUNCTIONS HAS OPERATED EFFECTIVELY AND FAIRLY

A. As ERISA Expressly Allows, Many Plans Rely On A Single Entity For Both Fiduciary And Funding Purposes

ERISA neither compels employers to establish benefit plans nor restricts the freedom of employers to define the benefits they choose to provide. *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995). Instead, under ERISA "employers have large leeway to design disability and other welfare plans as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). ERISA protects employee benefit plans by providing contractual and procedural safeguards: if an employer elects to establish a benefit plan, ERISA "simply requires [the] plan[] to afford a beneficiary some mechanism for internal review of a benefit denial, 29 U.S.C. § 1133(2), and provides a right to a subsequent judicial forum for a claim to recover benefits, § 1132(a)." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 385 (2002).

ERISA expressly permits a plan fiduciary responsible for evaluating benefit claims to serve as the plan's funding source. 29 U.S.C. § 1108(c)(3) (an individual or entity may "serv[e] as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest"). Under

§ 1108(c)(3), an insurer may assume the dual responsibility of making benefit determinations and paying claims, and an employer sponsoring a self-funded plan likewise may make its own benefit determinations. The provision marks a conscious departure from "from the absolute common law rule against fiduciaries' dual loyalties," and reflects a congressional judgment that "stringent prophylactic rules" should not be erected to prohibit the plan's funding source from making benefit determinations. *Donovan v. Cunningham*, 716 F.2d 1455, 1466-67 (5th Cir. 1983).

Decades of experience show that under tens of thousands of benefit plans administered by entities that fund the plans, such arrangements can provide substantial efficiency benefits for plans. For insured plans, relying on a single company to evaluate and pay benefit claims can reduce administrative costs and allows the insurer to leverage its expertise and familiarity with the terms of a plan. For self-funded plans, an employer can reduce costs by making benefit determinations in-house, rather than contracting with a third party to administer the plan. Although plan sponsors must consider a host of business and legal factors in selecting a fiduciary and funding source, and many choose to divide those responsibilities among different entities, many employers value the cost savings achieved by delegating the functions to a single entity. By achieving efficiencies in plan administration, employers can offer richer benefits to their employees, and avoid the negative impacts on morale and employee retention they inevitably experience when forced to reduce benefits or require

employee contributions simply because administrative costs cannot be adequately controlled.

Because of the efficiency advantages, it is now common for employer-sponsored benefit plans to lodge fiduciary responsibilities in the same entity that funds the plan. *See Guthrie v. Nat'l Rural Elec. Coop. Ass'n Long-Term Disability Plan*, 509 F.3d 644, 650 (4th Cir. 2007) (describing arrangement in which "a plan's administrator is also its funder" as "simple and commonplace" in the industry); *Hall v. UNUM Life Ins. Co.*, 300 F.3d 1197, 1205 (10th Cir. 2002) (noting that "[t]he administrator and the payor are often the same party for many ERISA benefit plans," and declining to depart from ordinary evidentiary rules "whenever the same party is the administrator and payor" because such arrangements are "commonplace").

B. Market Incentives And ERISA Regulations Ensure That Funding Entities Provide Proper Fiduciary Service

1. ERISA's regulatory framework, operating in conjunction with market incentives, both encourages plan formation and ensures that claims are fairly treated. Employer-sponsored long-term disability plans, like the one at issue in this case, cover well in excess of 28 million American workers, who received long-term disability coverage through 191,000 different benefit plans. Those insurers paid more than $7.2 billion in long-term disability insurance claims to more than 500,000 individuals in 2006, a 7.5% increase over benefits paid in the previous year. One-third of those individuals were ineligible for Social Security Disability Insurance. Council for Disability

Awareness, *The 2006 CDA Long-Term Disability Claims Review* 1, 3 (Apr. 2007), *available at* http://www.disabilitycanhappen.org/news/CDA_LTD_Claims_Survey_2006.asp (survey of companies representing over 75% of the commercial disability insurance marketplace in 2006).

2. Although many of those plans confer fiduciary responsibilities on the entity that funds the plan, the market for group insurance and the demands of plan participants effectively ensure that such entities make benefit decisions entirely in the interests of the plans they serve.

a. For insured plans, insurers with fiduciary claims duties have strong disincentives to systematically deny meritorious claims. As the First Circuit has explained, "employers have benefit plans to please employees and, consequently, will not want to keep an overly tight-fisted insurer." *Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 75 (2005). If insurers do not administer employee benefit plans to the actual benefit of employees, employers will simply retain other insurers to insure and administer the benefits. The market for group insurance is highly competitive, particularly for large employers like Sears, Roebuck and Company. Many employers renegotiate the terms of their insured benefit plans annually or biannually. They frequently issue requests for proposals, entertain bids from multiple insurers, and engage in extensive negotiation over the terms of the plan. Because employers who sponsor benefit plans "have the sophistication and bargaining power necessary to take their business elsewhere if an insurer . . . consistently denies valid claims," a practice of denying

claims improperly ultimately "would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers." *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1021 (7th Cir. 1998).

Market forces, in short, provide "an important competing motive" that minimizes the risk that an insurer will wrongfully deny claims to save money in the short term. *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998). Ignoring the effect of those forces, the Government incorrectly assumes that an insurer who provides fiduciary claims administration services will consider each transaction in isolation, seeking to "fill[] . . . its coffers" immediately. U.S. Cert. Br. 13. Any such insurer will not be in the business of insuring employee benefit plans for long. The Government's assumption also misapprehends the business of insurance. Insurers make money *not* by routinely denying claims, but by making careful actuarial predictions about potential liabilities, assuming that claims *will* be paid, and managing costs and risks on that basis. *See* Barry D. Smith & Eric A. Wiening, How Insurance Works 3-4, 8-9 (2d ed. 1994). The obligation to pay out claims, in other words, is an assumed and necessary function in the provision of insurance services.

b. Market incentives operate even more directly for self-funded plans. Whereas employers may insist that insurers administer benefits fairly to satisfy employees, when the employer itself is the fiduciary, the employer must respond directly to the expectations of the employees it wants to satisfy and the workforce it wants to attract and retain. It would be

"a poor business decision to make it a practice of resisting claims for benefits" because "[i]n the long run, such a practice would dampen loyalties of current employees while hindering attempts to attract new talent." *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995); *see Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1051 (7th Cir. 1987). By expressly permitting corporate officers to serve as plan fiduciaries, ERISA embodies a reasonable congressional judgment that "[t]he impact on a company's welfare of granting or denying benefits under a plan will not be sufficiently significant as to threaten the administrators' partiality." *Chalmers*, 61 F.3d at 1344.

c. Unsurprisingly, the foregoing market incentives have significant effects on plan benefit decisionmaking. Contrary to some popular lore, the overwhelming majority of employee benefit coverage claims are granted. A study of claims submitted in 2002 to health plans representing 26 million persons showed that 86 percent of all claims submitted were granted. Health Ins. Ass'n of America, *Results from an HIAA Survey on Claims Payment Processes* 10 (March 2003), *available at* www.ahipresearch.org/PDFs/21_ClaimsPaymentProcessesSurveyChartbook.pdf. And of the 14 percent that were denied, 48 percent were denied because they were duplicate submissions, and 20 percent were denied because the individual was no longer covered or the policy had lapsed. *Id.* at 10. Only about 3 percent of all claims were denied on the ground that the asserted benefit was not covered by the plan, 0.4 percent were denied for eligibility reasons, and one percent of claims were denied for other reasons. *Id.* There is simply no evi-

dence that employers and insurers are driven by self-interest to deny claims routinely – just the opposite is true.

3. Not all claims are granted, of course. But even when claims are initially denied, ERISA regulations requiring internal plan review ensure that claimants have an effective means of challenging the denial. ERISA requires that employee benefit plans provide effective notice of coverage denials and a reasonable opportunity for "full and fair review" of such decisions.[2] The Department of Labor has promulgated comprehensive regulations governing the appeal process. *See* 29 C.F.R. § 2650.503-1(h). The regulations compel benefit plans to establish and maintain a procedure under which there is an opportunity for full and fair internal review. *Id.* § 2650.503-1(h)(1). To satisfy the regulations, the review must take into account "all comments, documents, records, and other information submitted by the claimant relating to the claim," *id.* § 2560.503-1(h)(2)(iv), and must be conducted by someone other than the initial reviewer, with no deference to the initial decision, *id.* § 2560.503-1(h)(3)(ii). In cases involving the exercise of medical judgment, the plan administrator must consult with a health care professional in the rele-

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[2] *See* 29 U.S.C. § 1133(1) (requiring that plans "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reason for such denial, written in a manner calculated to be understood by the participant"); *id.* § 1133(2) (requiring that plans "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim").

vant field when conducting its review. *Id.* § 2560.503-1(h)(4). And in every case, the reviewer must provide a written explanation of the final decision with specific reference to pertinent plan provisions. *Id.* § 2560.503-1(j)(1).

Notably, when the DOL amended its regulations in 2001 to provide for this comprehensive internal review structure, it did *not* require sponsors to name a plan fiduciary distinct from the plan's funding source. *See* 66 Fed. Reg. 35887 (July 9, 2001) (codified at 29 C.F.R. pt. 2560).

The internal plan review guaranteed by DOL regulations provides significant protection for plan beneficiaries. Employer-sponsored health plans review more than 250,000 internal appeals annually. *See* David M. Studdert & Carol Roan Gresenz, *Enrollee Appeals of Preservice Coverage Denials at 2 Health Maintenance Organizations*, 289 J. Am. Med. Ass'n 864, 864 (2003). One leading study of health plans showed that plan fiduciaries granted benefits in approximately 42 percent of appeals. *Id.* at 866; *see also* AAHP, *Independent Medical Review of Health Plan Coverage Decisions* 1 (2001), *available at* http://www.ahip.org/content/default.aspx?bc=38|82|2246 (estimating that 49% of appeals in health plans result in grant of benefits).

Moreover, in *Rush Prudential*, this Court held that states could provide external review for health-benefit plan determinations (so long as such review did not act more like arbitration than a medical "second opinion"). 536 U.S. at 359. Consistent with that holding, forty-three states and the District of Columbia have external review programs that allow

beneficiaries to appeal denials of coverage. AHIP Center for Policy and Research, *Update on State External Review Programs* 2 (Jan. 2006), *available at* http://www.ahipresearch.org/pdfs/External_Reviews-Jan06.pdf. Those programs provide substantial additional protection for plan beneficiaries. *Id.* at 1, 6-7.

* * *

In sum, market incentives and regulatory protections together operate to ensure that plan benefit decisions are neither arbitrary nor self-interested. Absent evidence that bias or corruption influenced the process, there is no basis for judicial intervention into the plan administration process. To the contrary, such intervention would affirmatively undermine ERISA's objectives and the interests of plan beneficiaries, as the next section demonstrates.

II. A BENEFIT DETERMINATION BY AN ENTITY THAT ALSO FUNDS THE PLAN SHOULD NOT BE PRESUMPTIVELY SUBJECT TO HEIGHTENED JUDICIAL REVIEW

Where a plan specifies that a fiduciary's claim determination is discretionary, courts should not presume that *de novo* or "sliding-scale" or reasonableness review is appropriate merely because the fiduciary is also employed by or associated with the plan's funding source. Heightened judicial review of discretionary determinations by a plan fiduciary would frustrate ERISA's purpose of achieving uniformity and predictability in the oversight of benefit plans, and it would increase litigation costs by encouraging every individual whose claim is denied to

seek a second opinion in court. Instead, consistent with this Court's decision in *Firestone*, and with principles of trust law on which ERISA is predicated, reviewing courts should give no weight to a fiduciary's potential conflict in the absence of a showing that an improper consideration actually affected the decision.

A. Heightened Judicial Scrutiny Of Benefit Decisions By Entities Who Fund Plans Would Undermine ERISA's Purposes And Have Adverse Consequences For Benefit Plans

1. ERISA was designed "to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). To that end, ERISA "sets various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility," and it preempts most contrary state-law provisions. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983); *see* 29 U.S.C. § 1144(a). A single federal standard was "desirable," Congress concluded, "because it will bring a measure of uniformity in an area where decisions under the same set of facts may differ from state to state." H.R. Rep. No. 93-533, at 12 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650.

Congress also recognized the interest of employers in the uniform interpretation and application of their benefit plans. Many large employers provide plans that extend to beneficiaries in multiple jurisdictions, and such plans would be threatened if they were "subject to different legal obligations in different States." *Egelhoff v. Egelhoff*, 532 U.S. 141, 148

(2001). Consistent with its purpose to ensure "nationally uniform plan administration," ERISA therefore "require[s] that plans be administered, and benefits be paid, in accordance with plan documents." *Id.* at 148, 150.

A rule that subjects the decisions of fiduciaries with potentially conflicting interests to *de novo* or otherwise heightened judicial review would undermine ERISA's purpose of ensuring uniformity in the interpretation and administration of benefit plans. Instead of a single fiduciary, chosen by the plan settlor and vested with discretion in making benefit determinations, every federal district court would have authority to second-guess benefit determinations by reweighing the evidence and construing the plan documents. Because courts entertain only one case at a time, they would have no obligation to respect the fiduciary's decisions concerning similarly situated claimants or to consider the consequences of a decision for other beneficiaries. *See Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003, 1006 (4th Cir. 1985) (deferential review "exists to ensure that administrative responsibility rests with those whose experience is daily and continual, not with judges whose exposure is episodic and occasional"). This Court recently made a similar point (albeit in a different context) about the limited capacity of decisionmakers in case-by-case adjudication, compared with those charged with taking a broader view. *See Riegel v. Medtronic, Inc.*, No. 06-179 (Feb. 20, 2008), slip op. 11-12 ("A jury, on the other hand, sees only the cost of a more dangerous design, and is not concerned with its benefits; the patients who reaped those benefits are not represented in court."). And because

district courts would seldom be bound by precedent in interpreting the terms of a plan, they would be free to adopt constructions that conflict with those of other courts or the plan administrator. Indeed, the risk of inconsistent interpretations is among the reasons that plan settlors choose to give the fiduciary discretionary authority to interpret the plan. *See Firestone*, 489 U.S. at 111 (noting that "[a] trustee may be given power to construe disputed or doubtful terms, and in such circumstances the trustee's interpretation will not be disturbed if reasonable") (citing Bogert & Bogert, Law of Trusts and Trustees § 559, at 169-71 (2d rev. ed. 1980)).

The splintered decisions of courts of appeals on the questions presented in this case illustrate the potential for inconsistency when federal courts – contrary to the wishes of the plan sponsor – conduct *de novo* or "sliding scale" or reasonableness review of benefit determinations because of a potential conflict of interest. Even courts that have *agreed* on the existence of a relevant conflict of interest have differed sharply as to how that conflict affects the standard for reviewing the claim. *Compare* Pet. App. 10a (potential conflict must be weighed alongside other factors when reviewing for abuse of discretion); *with Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000) ("sliding scale" review depending on nature of conflict and other circumstances); *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 87 (5th Cir. 1999) (same); *and Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2d Cir. 2000) (*de novo* review). Appellate courts also have fractured over the claimant's ability to introduce new evidence before the reviewing court, *see*

Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 967 (9th Cir. 2006) (en banc), the burden of proof and persuasion in cases involving a potential conflict, *see Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006 (10th Cir. 2004), and the circumstances, if any, in which a claimant may obtain discovery, *see Semien v. Life Ins. Co. of N. Am.*, 436 F.3d 805, 814-15 (7th Cir. 2006), *cert. denied*, 127 S. Ct. 53 (2006). Such procedural differences abound at the district court level, and an employer seeking predictability in the administration of its benefits plan should have the ability, consistent with the purposes of ERISA, to obtain uniformity in the review of its benefits determinations by vesting discretion in a fiduciary of its choice.

2. Another central purpose of ERISA is to avoid "creat[ing] a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). ERISA and its accompanying regulations were designed to promote the internal resolution of claims and to encourage non-adversarial proceedings, minimizing "both the likelihood of subsequent federal litigation and the costs that would be attendant thereto." *Jewell v. Life Ins. Co. of N. Am.*, 508 F.3d 1303, 1308 (10th Cir. 2007).

Heightened judicial review of benefit determinations in cases involving an entity with both fiduciary claims responsibilities and non-fiduciary funding obligations would be inconsistent with that purpose because it would increase litigation and administrative costs in three ways. First, non-deferential review would encourage every individual with a borderline

claim denied by such an entity to seek a second opinion in federal court, directly contrary to ERISA's objective to promote internal resolution of claims. Second, even individuals with weak claims would have a stronger incentive to file a lawsuit in the hope of obtaining a favorable settlement. Third, non-deferential review would increase the likelihood of reversal, even in cases where the fiduciary acted reasonably. As a result, plans would be forced to spend more money, both to defend against the greater volume of litigation and to pay out claims properly denied by the fiduciary in the reasonable exercise of its discretion, as contemplated by the plan. Employers might respond to those costs in various ways – by reducing the available coverage, paying increased premiums, or discontinuing the plan entirely – but none of them would redound to the benefit of plan participants in the long run.

This Court in *Firestone* acknowledged the possibility "that a *de novo* standard would encourage more litigation" and drive up costs, and emphasized that parties are free to choose a standard of review based on those considerations. 489 U.S. at 114-15. In this case, and under tens of thousands of similar employer-sponsored plans, the employer has voluntarily chosen to vest a single entity with the duty to make benefit determinations and the responsibility to pay claims. That arrangement is expressly permitted by ERISA, and many employers prefer it, notwithstanding the potential conflict of interest, because it improves plan efficiency and thereby conserves plan funds. *See supra* at 7-8. Imposing non-deferential review on the benefit determinations of all entities with funding obligations not only would

contravene one of the central purposes of ERISA, but would frustrate the objectives of employers who made the considered judgment that vesting both responsibilities in a single entity would maximize the resources available to provide plan benefits. *Id.*

B. Courts Should Give No Weight To A "Potential Conflict" In The Absence Of A Showing That The Benefits Decision Was Infected By An Improper Consideration

In rare circumstances, a fiduciary's *potential* conflict of interest may develop into an *actual* conflict of interest that "must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Firestone*, 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187, cmt. d (1959)). Before the conflict is entitled to any weight, however, a claimant must make a substantial showing that the potential conflict actually infected the challenged benefit determination.

1. When a benefit plan confers discretion on the plan administrator to determine benefit eligibility, a court's power to review coverage decisions is highly circumscribed. As the Court explained in *Firestone*, principles of trust law guide the application of ERISA in this context, and under those principles when "discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion." 489 U.S. at 111 (quoting Restatement (Second) of Trusts § 187). A court "*will not interfere* to control [trustees] in the exercise of a discretion vested in them by the instrument under which they act." *Id.* (quoting *Nichols v. Eaton*,

91 U.S. 716, 724-25 (1875) (emphasis altered)). In the law of trusts, "[t]he cases are numerous in which it has been held that where discretion is conferred upon the trustee with respect to the exercise of a power the court will not interfere with him in his exercise or failure to exercise the power so long as he is not guilty of an abuse of discretion." 3 Scott & Fratcher, The Law of Trusts § 187 (4th ed. 1988).

The same trust principles relied upon by the Court in *Firestone* provide clear guidance as to when and how a conflict of interest affects the abuse-of-discretion analysis. As the Restatement (Second) of Trusts explains:

> The court will control the trustee in the exercise of a power . . . where he acts from a motive other than to further the purposes of the trust. Thus, if the trustee in exercising or failing to exercise a power does so . . . to further some interest of his own or of a person other than the beneficiary, the court will interpose. *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.*

Restatement (Second) of Trusts § 187 cmt. g (emphasis added). A potential conflict of interest is only a fact "to be considered" in determining whether the trustee was *actually* motivated by the conflict – the relevant question when evaluating whether the trustee abused its discretion. *Id.*; *accord* Restatement (Third) of Trusts § 50(1) cmt. b (2003) (in reviewing discretionary decisions by a trustee, "[c]ourt inter-

vention may be obtained to rectify abuses *resulting from* bad faith or improper motive") (emphasis added).

This principle of trust law supports the approach of those appellate courts holding that the review of a plan administrator's discretionary eligibility determination remains fully deferential, even when the administrator is also the plan's funding source, unless and until the claimant produces specific evidence (beyond the conflict itself) establishing that the non-fiduciary funding obligation role actually affected the fiduciary's judgment. *See Pulvers*, 210 F.3d at 92 (an insurer's role as plan administrator "is alone insufficient as a matter of law to trigger stricter review," and the claimant must produce "evidence that [its] decision was actually affected by a conflict of interest"); *Buttram v. Central States, Se. & Sw. Areas Health & Welfare Fund*, 76 F.3d 896, 900 (8th Cir. 1996) ("[A]bsent material, probative evidence, beyond the mere fact of the apparent [conflict of interest], tending to show that the administrator breached his fiduciary obligation, we will apply the traditional abuse of discretion analysis to discretionary trustee decisions." (citations omitted)). The bare fact that the same entity serves as the funding mechanism and evaluates benefit claims – an arrangement explicitly allowed by statute and intended by the plan sponsor – is entitled to no weight in determining whether the fiduciary abused its discretion.

2. To establish an actual conflict of interest relevant to judicial review of a benefit determination, a claimant should be required to make a threshold showing of bias or corruption based on the adminis-

trative record. *See Rush Prudential*, 536 U.S. at 384 n.15 (under *Firestone*, a conflict of interest affects the abuse-of-discretion standard only if "plausibly raised"). The terms of the plan itself, for example, may create a prima facie inference of bias. *See Pegram v. Herdrich*, 530 U.S. 211, 227 n.7 (2000) (offering the example of a plan that provides "a bonus for administrators who denied benefits to every 10th beneficiary"); *Buffonge v. Prudential Ins. Co. of Am.*, 426 F.3d 20, 31 n.15 (1st Cir. 2006) (addressing question whether insurer "intentionally set up a biased process"). The claim file may also reveal a complete abdication on the part of the plan administrator, as in a case where the decisionmaker failed to consult any relevant evidence, which can give rise to an inference that the administrator acted pursuant to an improper consideration. *See* Restatement (Second) of Trusts § 187 cmt. h (the court will interpose where the exercise of a power "is left to the judgment of the trustee and he fails to use his judgment," as in a case where the trustee acts "without knowledge of or inquiry into the relevant circumstances and merely as a result of his arbitrary decision or whim"). In that situation, however, the proper course for a court should be to remand the decision to the plan for reconsideration by the plan fiduciary in accordance with proper procedures, including the full and fair internal review required under DOL regulations, as discussed above, *supra* at 12-13. *See*, *e.g.*, *Buffonge*, 426 F.3d at 31-32; *Smith v. Cont'l Cas. Co.*, 450 F.3d 253, 265 (6th Cir. 2006); *Quinn v. Blue Cross & Blue Shield Ass'n*, 161 F.3d 472, 477-78 (7th Cir. 1998). The question whether a decision was infected by an improper consideration should be asked only after the decision has been

properly made in accordance with appropriate internal review procedures.

A contrary rule that presumes bias or corruption on the part of every fiduciary employed by a plan funding source, or that allows plaintiffs to conduct discovery into the fiduciary's motives without any concrete basis in the administrative record, would significantly increase litigation costs for benefit plans, contrary to the purposes of ERISA. *See Jewell*, 508 F.3d at 1308 ("[c]onfining review in general to the administrative record . . . is important for a variety of reasons related to the goals of ERISA," including the minimization of litigation costs). As the Seventh Circuit has explained, "onerous discovery before an ERISA claim can be resolved would undermine one of the primary goals of the ERISA program: providing 'a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously.'" *Semien*, 436 F.3d at 815 (quoting *Perry v. Simplicity Eng'g*, 900 F.2d 963, 967 (6th Cir. 1990)). For that reason, discovery must be "limit[ed] . . . to those cases in which it appears likely that the plan administrator committed misconduct or acted with bias." *Id.* at 816. The bald assertion of a potential conflict of interest arising from a fiduciary's association with the plan's funding mechanism cannot suffice to justify such discovery – "specific factual allegations of misconduct or bias in a plan administrator's review procedures" must be required. *Id.* at 815-16.

Even in the rare case in which a claimant establishes that the plan administrator acted pursuant to an actual conflict of interest, *Firestone* makes clear that a court should not adopt a different standard of

review. Instead, the conflict "must be weighed as a 'facto[r] *in determining whether there is an abuse of discretion*.'" *Firestone*, 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d (alteration in original, emphasis added); *Rush Prudential*, 536 U.S. at 384 n.15 (explaining that under "*Firestone Tire* itself," "any conflict of interest on the plan fiduciary's part," if "plausibly raised," would affect "review for abuse of discretion"). The ultimate inquiry is whether the fiduciary "act[ed] beyond the bounds of a reasonable judgment," not whether "the court would have exercised the [discretionary] power differently." Restatement (Second) of Trusts § 187 cmts. e, i. Accordingly, a fiduciary's determination should be affirmed, notwithstanding an actual conflict of interest, if it is supported by substantial evidence such that a reasonable person could have reached the same conclusion. *See, e.g.*, *Fletcher-Merrit v. NorAm Energy Corp.*, 250 F.3d 1174, 1179 (8th Cir. 2001); *Miller v. United Welfare Fund*, 72 F.3d 1066, 1071 (2d Cir. 1995); *Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 382 (10th Cir. 1992).

CONCLUSION

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

Respectfully submitted,

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