No. 06-923

In the Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK & CO,
Petitioners,
v.
WANDA GLENN .

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF THE AMERICAN DENTAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

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BRIEF OF THE AMERICAN DENTAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

INTEREST OF *AMICUS CURIAE*[1]

The American Dental Association (ADA) is the world's largest professional association of dentists. The ADA is committed to the public's oral health, and to the ethics, science and professional advancement of dentistry. On behalf of its more than 155,000 members, the ADA occupies a prominent role in leading the profession through initiatives in advocacy, education, research, and the development of standards that are essential for the safe, appropriate, and effective delivery of oral healthcare. The Association is vitally concerned with access to care issues and serves as a principal advocate on issues affecting oral health.

The Association's advocacy on such important health issues includes submissions to legislative bodies and judicial tribunals. In cases that address questions of concern to the Association, its members, and the public, the ADA has participated and will continue to participate as *amicus curiae*. This is just such a case. The arguments advanced by the petitioners – particularly their negative comments

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[1] The parties have consented to the filing of this brief, as reflected in letters filed with the Clerk of Court. Pursuant to Supreme Court Rule 37.6, *amicus curiae* states that no counsel for a party 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 other than *amicus curiae*, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

about healthcare providers – could have adverse ramifications for the dental profession and the public. Accordingly, the ADA submits this *amicus curiae* brief so that the Court will have a fuller, more accurate, and better informed understanding of the context in which the issues in this case affect the dental profession and the public.

SUMMARY OF ARGUMENT

In seeking reversal of the Sixth Circuit's judgment in this case, petitioners advocate positions that are contrary to ERISA's statutory language and legislative purpose, and also contrary to judicial construction of the fiduciary duties owed to ERISA plan beneficiaries. Accordingly, on the grounds explained in detail in respondent's brief, the decision below should be affirmed.

In addition to the sound rationale for affirmance set forth by respondent, there are further compelling reasons why this Court should reject petitioners' contentions. First, petitioners' entire analytical construct depends on assumptions that lack an empirical or evidentiary basis. Indeed, petitioners' contentions are directly contrary to scholarly studies and to the experience of courts that have dealt with the real-world situations arising in the administration of ERISA plans.

Among the most readily identifiable flaws in petitioners' analysis are the propositions that: (1) it is not a conflict of interest for an ERISA insurer to also serve as plan administrator; (2) it is in the long-term interest of every dual-role insurer-administrator to make all eligibility decisions fairly

and accurately, without regard for the short- or long-term financial ramifications; (3) every dual-role insurer/administrator will, in every case, make the same eligibility determination that would have been made by an administrator whose fiduciary duty to plan beneficiaries constitutes his sole, undivided role.

These flaws expose the error in petitioners' contention that the clear conflict of interest under which dual-role insurers/administrators must labor should be totally ignored by courts that sit in review of claims eligibility decisions. The ineluctable fact is, such conflicts are real, pervasive and affect benefits decisions in multiple ways, whether consciously or non-consciously, whether overtly or subtly.

The regime that petitioners posit would have a particularly deleterious impact on the relationship between healthcare professionals and their patients. Treatment and care decisions by dentists and patients must have as their paramount objective the best interest of the patient. That requires open and candid communication. And it requires respect for the judgments reached by trained professionals with the closest first-hand knowledge of their patients. Because petitioners' arguments would far too facilely reject the healthcare provider's professional assessment in favor of the second-guessing by an insurer/administrator with a financial conflict of interest, this Court should affirm the judgment in this case in favor of respondent.

ARGUMENT

THE INHERENT CONFLICT THAT EXISTS FOR DUAL-ROLE INSURERS/ ADMINISTRATORS IS PROPERLY THE SUBJECT OF ATTENTION BY COURTS REVIEWING COVERAGE DECISIONS

On multiple levels, there is no merit to petitioners' contention that the inherent conflict of interest affecting dual-role insurers/administrators should be disregarded or given *de minimis* weight by reviewing courts. In order best to comprehend the pervasive error in petitioners' argument, it is advisable to begin with a central flaw on which petitioners' entire analysis rests. The foundation on which petitioners build their analytical structure is the premise that a dual-role administrator has only a *potential* conflict of interest between its fiduciary responsibility to plan beneficiaries and its fiscal relationship to the insurance carrier. In petitioners' view, this potential conflict of interest is not an actual conflict of interest. But that counterfactual premise is belied by the law of trusts on which Congress relied in enacting ERISA. Petitioners' premise is also belied by the experience of implementing ERISA and other analogous programs. And it is further belied by scholarly studies of human behavior in the fields of economics and psychology.

In every other context, the inherent tension between administering a fund (determining eligibility for coverage) and bearing the costs of payments from that fund is understood to be a conflict of interest. To be sure, in certain limited

circumstances such conflicts are tolerated – even permitted – but only when accompanied by the hallmarks of full disclosure, unambiguous waiver, and transparency providing assurance of compliance with fiduciary duties. Congress did not depart from this model in enacting ERISA. In allowing for the possibility that a single entity – or two related entities – could serve as a plan's benefit administrator and underwriting insurer, Congress did not determine that such dual roles do not constitute an actual conflict of interest. Rather, Congress intended that courts would be cognizant of and sensitive to such conflicts of interest in reviewing the decisions of dual-role insurers/administrators. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) ("if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed . . . . ").

A. Dual-Role Insurers/Administrators Act Under A Conflict Of Interest.

For years, this Court and the lower federal courts that are on the front line of decision-making under ERISA have understood that the functions of administrator and underwriter of a benefit program are inherently in tension. *See Firestone,* 489 U.S. at 113; *Denmark v. Liberty Life Assurance Co. of Boston*, 481 F.3d 16, 29-31 (1st Cir. 2007); *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997). On the one hand, the insurer has an ultimate interest in maximizing the margin between benefit outlays and funds received in underwriting. *See Armstrong*, 128 F.3d at 1265; *see also Doe v.*

Travelers Ins. Co., 167 F.3d 53, 57 (1st Cir. 1999); *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998); *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1561-62 (11th Cir. 1990). On the other hand, it is bound as a fiduciary to provide benefit coverage to plan participants without regard to effect on the funding entity. *See Pegram v. Herdrich*, 530 U.S. 211, 223-24 (2000). In permitting an insurer both to underwrite and administer ERISA plans, Congress did not declare the resulting conflict of interest to be nonexistent – or merely "potential." Nor did Congress absolve the insurer/administrator of those conflicts or preclude courts from considering the conflicts in any judicial review of benefit determinations. Rather, Congress drew extensively on well-established principles from the law of trusts. *Firestone,* 489 U.S. at 110. Under these principles, the existence of a conflict of interest necessarily constitutes an important consideration in judicial assessment of actions undertaken by a fiduciary.

1. A dual-role insurer/administrator's long-term interest in denying claims will be reflected in improper rejection of individual claims.

A second level of flawed generalizations on which petitioners rely consists of their contentions that: (1) an insurer's long-term economic interest will always favor paying claims – even close claims – promptly and fully; and (2) an insurer's dual-role as plan administrator is fully consistent with its fiduciary duties to patients and imposes no impediment to the pursuit of such beneficent long-term objectives.

Reality is contrary to petitioners' economic fantasy. A more discerning analysis reveals that the interest of an insurer who is both underwriter and benefits administrator is to reach an optimal balance between immediate profit maximization and alienation of its customers (which are the employers, not the insured employees such as respondent Glenn), within the constraints of the applicable regulatory scheme. *See Brown*, 898 F.2d at 1561. Those economic forces do not preclude bias or misconduct in administering an ERISA plan.

Courts have seen these principles at work in a number of areas of economic regulation. For example, just as a monopolist has an incentive to charge prices that are both supra-competitive and just below what will entice competition to enter the market, an insurer wearing two hats has an incentive improperly to deny claims up to a level just below what will trigger large employer defections, state regulatory investigations or sanctions.

Decision-making by rational agents can reflect very complex sets of interactions. *See generally* Colin F. Camerer, *Behavioral Game Theory: Experiments in Strategic Interactions*, 465-73 (Princeton 2007). A monopolist should be able to see that it will gain overall profit if it is willing to accept a longer time-line. It should price near, but short of, the limit. Similarly, it should tolerate small competitors taking a small share of the market at lower prices operating under its umbrella. The existence of the small competitors makes competition appear more robust than it really is. A monopolist need not (and

rationally should not) immediately raise prices to the full monopoly return, *e.g.*, limit pricing or umbrella pricing.[2]

An insurer that both funds and administers an ERISA plan has a long-term interest to deny claims at rates just below what will alienate its customers and their employees. In this respect, the insurer's position is analogous to that of a monopolist for whom limit pricing or umbrella pricing[3] is often the optimal strategy. For the dual-role insurer/administrator, that strategy maximizes its profit on underwriting. The rational insurer will aim

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[2] "Limit pricing" is setting one's price just below the level that a prospective entrant to the market would need to charge in order to sustain a successful entry. *Phototron Corp. v. Eastman Kodak Co.*, 842 F.2d 95, 101 (5th Cir. 1988). While detecting and remedying limit pricing can be difficult, it nevertheless exists and harms competition. *See, e.g.,* Phillip E. Areeda & Herbert Hovenkamp, *Antitrust Law* ¶ 736b1 (3d ed. 2002) ("The limit price is intended by the monopolist to impair the opportunities of rivals, and, if successful, it does prevent competition from arising.").

[3] "Umbrella pricing" is where a firm with market power raises prices to a level that allows small, inefficient firms to enter the market and gain limited market share. *See* Gloria J. Hurdle & Henry B. McFarland, *Criteria for Identifying Market Power: A Comment on Baumol and Swanson*, 70 Antitrust L.J. 687, 693-94 (2003). While entry may appear to undermine the conclusion that the monopolist actually possesses market power, such a conclusion overlooks the possibility that the new entrants may be less efficient and that "[a] firm with market power generally will find it profitable to lose some share of the sales in a market in order to charge higher prices on the remaining sales." *Id.*

to deny as many claims as it can without crossing over into such pervasive denial that it will suffer (comparative) customer defections or an impaired reputation. Under that economically rational strategy, close cases – which are the cases most likely to be reviewed by a court and most likely to be adversely affected by the institutional conflict of interest – will suffer particularly from the effect of the inherent bias that flows from the conflict.

These incentives flow downward to affect individual benefit decisions by administrators who know, consciously or not, that their employer (the insurer) benefits from denying claims. Since no single improper denial will cause defection of customers, who are the employers of beneficiaries rather than the beneficiaries themselves, there is no effective counterbalance to the administrator's knowledge of the insurer's financial interest in denying individual claims.

Knowledge of the insurer's interests need not be at the forefront of the administrator's mind to affect the evaluation process and decision. Cognitive science teaches that biasing of the sort at issue here is no less pervasive because non-conscious.[4] There is

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[4] Subtle, non-conscious bias is still bias. For example, studies show that as orchestras moved to auditions where the performer was not seen and entered silently, the gender mix of new players altered. The increase in women members appears related almost entirely to removal of signals (such as the sound of high heels on wooden floors) which unconsciously biased evaluators. *See* Cecilia Rouse & Claudia Goldin, *Orchestrating Impartiality: The Impact of Blind Auditions on Female Musicians,* 90(4) American Economic Review 715-41 (Sept. 2000).

extensive, robust evidence that even highly self-aware individuals are influenced, albeit unconsciously, by economic interests, investment in prior decisions, and so on. For example, scholarly studies indicate that results of scientific research can have a positive correlation with funding source.[5] Further studies show that information and evidence is assessed to fit existing conclusions;[6] that inconsistent and inconvenient evidence is subjected to critical, unfavorable scrutiny and is devalued;[7] and that even the most scrupulous person tends to

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[5] *See, e.g.*, Justin E. Bekelman, Yan Li, & Cary P. Gross, *Scope and Impact of Financial Conflicts of Interest in Biomedical Research: A Systematic Review*, 289(4) JAMA 454-65 (2003); Joel Lexchin, Lisa A. Bero, Benjamin Djulbegovic & Otavio Clark, *Pharmaceutical Industry Sponsorship and Research Outcome and Quality: Systematic Review*, 326 Brit. Med. J. 1167-70 (2003).

[6] Keith J. Holyoak & Dan Simon, *Bidirectional Reasoning in Decision Making by Constraint Satisfaction,* 128 J. Experimental Psychol. – General 3-31 (1999); J. Edward Russo, Margaret G. Meloy, & Victoria H. Medvec, *Predecisional Distortion of Product Information*, 35 J. Marketing Research 438-52 (1998); J. Edward Russo, Victoria H. Medvec, & Margaret G. Meloy, *The Distortion of Information During Decisions*, 66(1) Org. Behavior and Human Decision Processes 102-10 (1996); Derek J. Koehler, *Explanation, Imagination, and Confidence in Judgment*, 110(3) Psychol. Bulletin 499-519 (1991); Charles G. Lord, Lee Ross, & Mark R. Lepper, *Biased Assimilation and Attitude Polarization: The Effects of Prior Theories on Subsequently Considered Evidence*, 37(11) Journal of Personality and Social Psychol. 2098-109 (1979).

[7] Thomas Gilovich, *How We Know What Isn't So: The Fallibility of Human Reason in Everyday Life* (Free Press 1991).

overvalue his or her own assessments and interests.[8] Since these sorts of effects can be found even in cases where highly skilled individuals are on guard against the influences, how much more likely is it that decisions made by less well-trained claims administrators acting on individual cases will be unaffected by bias resulting from an inherent conflict of interest?[9] Clearly, there is ample room for a structural conflict of interest to affect claims decisions.

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8 *See, e.g.,* Don A. Moore, Philip E. Tetlock, Lloyd Tanlu, & Max H. Bazerman, *Conflicts of Interest and the Case of Auditor Independence: Moral Seduction and Strategic Issue Cycling* 19 (American Accounting Association, Working Paper # 03-115, 2004).

9 *See, e.g.,* Thomas A. Buchman, Philip E. Tetlock, & Ronald O. Reed, *Accountability and Auditors' Judgments About Contingent Events*, 23(3) J. Bus. Fin. & Accounting 379-98 (1996); Andrew D. Cuccia, Karl Hackenbrack, & Mark W. Nelson, *The Ability of Professional Standards to Mitigate Aggressive Reporting*, 70(2) Accounting Rev. 227-48 (1995).

2. Petitioners' arguments are contrary to this Court's requirement that a dual-role insurer/administrators' inherent conflict of interest be recognized in judicial assessments of claims rejections.

In positing the contention that courts should ignore – or give only *de minimis* weight to – a dual-role insurer/administrator's conflict of interest, petitioners' view is directly contrary to multiple decisions of this Court. In *Firestone,* this Court required that, where an ERISA fiduciary has a conflict of interest, a reviewing court "must" consider and give weight to the conflict "as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (citation omitted). That sensible rule is fully consistent with the established judicial recognition that even where an insurer is permitted to function in dual roles, "ERISA does require . . . that the fiduciary with two hats wear only one at a time, and wear the fiduciary hat when making fiduciary decisions." *Pegram, 530 U.S. at 225.* In *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 n.15 (2002), this Court elaborated on the same point, observing that it is appropriate to keep an "eye peeled for conflict of interest." These teachings are fundamentally at odds with the pernicious new standard that petitioners urge.

The wisdom of this Court's guidance in *Firestone* is reflected in the subsequent decisions of lower courts that have been called upon to consider decisions made by dual-role insurers/administrators. For example, in *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967 (9th Cir. 2006), the court discerned

that *Firestone* advanced ERISA's objectives by discarding an approach that "wrongly aligns incentives." As the Ninth Circuit explained, the danger inherent in the type of regime that petitioners advocate is that it fails to encourage administrators "affirmatively to demonstrate their impartiality and the reasonableness of their decisions," and that it instead rewards administrators "for suppressing dissent and denying claims with as little explanation as possible." *Id.*

Similarly, the Third Circuit pointed out in *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388 (3d Cir. 2000) that ERISA litigation typically occurs only in close cases and:

> [T]here would seem to be insufficient incentive for the carrier to treat borderline cases (unlikely to become causes celebres) with the level of attentiveness and solicitude that Congress imagined when it created ERISA "fiduciaries." Rather, insurance carriers have an active incentive to deny close claims in order to keep costs down and keep themselves competitive so that companies will choose to use them as their insurers . . . . To amplify, while in a perfect world, employees might pressure their companies to switch from self-dealing insurers, there are likely to be problems of imperfect information and information flow.

In short, courts that have addressed the empirical records of conduct by dual-role insurers/administrators understand precisely why the structural conflict of interest cannot be ignored or glossed over with minimal concern.

B. The Nature Of The Patient-Provider Relationship Necessarily Requires That There Be Minimal, If Any, Interference with the Provider's Decision-Making and that the Provider's Assessments be Given Appropriate Respect.

The bond between patient and healthcare provider, whether dentist or physician, begins as and remains a type of fiduciary relationship. Dentists and physicians are bound from the outset to consider first and only the health and well-being of the patient. Providers, who deal directly with patients undeniably are better situated to assess the needs of patients than are benefit plan administrators.

1. Providers have direct duties of care to attend to their patients' best interests.

Healthcare providers owe direct professional, moral, and legal duties of care to place paramount importance on the patients' best interests and health care. Dentists are required to "have the benefit of the patient as their primary goal." ADA, *Principles of Ethics and Code of Professional Conduct*, Preamble, http://www.ada.org/prof/prac/law/code (last updated 2005). This tenet is the cornerstone for the principles embodied in dentistry's ethics code. For example, according to the principle of beneficence dentists are under an affirmative duty to

"promote the patient's welfare." *Id.*, Section 3. Pursuant to the principles of veracity and justice, dentists must forthrightly disclose conflicts of interests and deal truthfully and fairly with patients, and are admonished not to exploit patient trust for their own financial gain. *Id.*, Sections 4 & 5. Safeguarding patient welfare is an integral responsibility for the dentist in the dentist-patient relationship.

Treating physicians, too, must "place[e] patient welfare before all other concerns," and must never "place their own financial interests above the welfare of their patients." AMA, *Code of Medical Ethics,* E-8.02, 8.03, *available at* http://www.ama-assn.org/ama/pub/category/ 2498.html (last updated 1998, 1994, respectively); *see also id.* E-10.015 ("ethical obligations to place patients' welfare above their own self-interest"); AMA, *Principles of Medical Ethics,* Principle VIII, *available at* http://www.ama-assn.org/ama/pub/ category/2512.html (last updated 2001) (a physician "shall, while caring for a patient, regard responsibility to the patient as paramount"). Psychologists have similar duties towards patients. *See, e.g.,* APA, *Ethical Principles of Psychologists and Code of Conduct* 2002, Principle A, *available at* http://www.apa.org/ethics/code2002.pdf (last updated 2002).

2. Providers are better situated to assess patient needs than are plan administrators.

Plan administrators do not examine or treat patients. Their expertise does not lie in recognition of the best interests of the patient. Nor is the

administrator devoted to the well-being and healthcare needs of the patient. This is in sharp contrast to the healthcare provider, who has a direct duty of care.

Of course, healthcare providers are far more likely to be engaged directly with the patient than is a plan administrator. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 832 (2002). A healthcare provider interacts with the patient on a face-to-face basis. The diagnostic process that results from physical examinations and ongoing communications leads to individual treatment recommendations. This personal engagement is particularly important because so much of diagnosis and treatment involves assessment of a patient's articulation of his or her somatic impression. Assessment of pain, for example, requires careful attention to how a patient describes and expresses physical sensations. Such information is uniquely accessible to the provider, as opposed to an administrator, yet is essential for proper claim evaluation. *See, e.g.,* Susan A. Flocke, *The Impact of Insurance Type and Forced Discontinuity on Delivery of Primary Care*, 45 J. Fam. Prac. 129, 132 (1997); *Textbook of Primary Medical Care Medicine*, 93 (John Nobel ed., 3d ed. 2001) (discussing patient's report of pain as "the most reliable information available").

3. Even in the rare situations when a provider may have a conflict of interest with the patient, any such conflict will be less severe than the pervasive institutional conflict of interest that affects dual-role insurers/administrators.

Petitioners devote extended argument to the proposition that healthcare providers may, at times, face conflicts of interest in dealing with patients. That, of course, can occur; but there are powerful reasons why the possibility of a rare provider-patient conflict should not be the catalyst for a legal rule that, in every situation, eliminates judicial scrutiny of the conflict of interest that necessarily besets the dual-role insurer/administrator.

There are, in the first instance, professional standards that govern financial and ethical conflicts when they arise. ADA, *Principles of Ethics and Code of Professional Conduct*, *supra,* 5.C, 2.B.1.; AMA, *Code of Medical Ethics*, *supra*, E-8.032, 8.035. In any event, such conflicts are both rarer, and more easily ameliorated than the conflicts continually affecting a dual-role insurer-administrator. In many instances the matter can satisfactorily be addressed through full disclosure. In others, a neutral second opinion will alleviate the problem. In rare situations, the proper course may be for the provider to withdraw. But it would never be correct for a provider to follow the approach that the dual-role insurer/administrator takes, *viz.,* to characterize its conflict as merely "potential" and then assert that a reviewing body should ignore the existence of a conflict altogether.

The conflict of a dual-role insurer/ administrator is profoundly different from the rare, incidental, healthcare provider conflicts of interest. The former conflict goes to the very recognition of the patient's well-being and needs, because the dual-role insurer/administrator's interests cut against — in

fact they are diametrically opposed to – recognition of claim validity. Accordingly, the insurer's interests are directly at odds with the interests of the patient (or plan beneficiary), a person to whom a fiduciary duty is owed.

The conflict of interest of a dual-role insurer/administrator is also more pervasive and insidious because it is structural. For the dual-role insurer/administrator, the conflict of interest may permeate all of its decision-making.

At the end of the day, the permutations petitioners offer for ignoring or minimizing judicial consideration of their inherent conflicts of interest are all contrary to the language and purpose of ERISA and contrary to sound public policy. There should be no doubt that the balance carefully crafted by Congress would be disturbed if a provider's alleged conflict of interest could be considered in a review by a dual-role insurer/administrator but the insurer/administrator's inherent conflict of interest could not be considered by a reviewing court.

C. Administrator Decisions Made Under A Conflict Of Interest Should Be Subject To Substantive Review That Weighs The Conflict As A Factor.

Decision-making is intrinsically suspect when a conflict of interest exists – especially in the context of a fiduciary relationship. The subtle influence of structural conflicts, no less than the overt pressure of direct monetary reward, justifies searching review of the resulting decisions. Of course, that does not mean that in every instance the dual-role insurer/administrator's decision must be rejected. Nor does a standard that acknowledges the influence of such conflicts necessarily mean that there can be no flexibility in reviewing administrator decisions. The fact of a conflict should be considered as one, albeit initially significant, factor to be weighed in review. Where there are additional signs of conflict, *e.g.,* the absence of insulation of those making claims decisions, the presence of performance metrics or compensation criteria that reward claim denials, a reviewing court should look more closely at the decision. Similarly, where there are additional indications that a conflict has overtly infected administrative decisions, courts should be empowered to provide an appropriate cure.

Petitioners' invitation for this Court – and all courts reviewing decisions by dual-role insurers/administrators – to ignore conflicts of interest is flatly inconsistent with ERISA's grounding in and development from the law of trusts. Indeed, "[u]nder ERISA, plan administrators are, for most purposes, treated like common-law trustees."

Post v. Hartford Ins. Co., 501 F.3d 154, 162 (3d Cir. 2007) (citing *Firestone*, 489 U.S. at 110)). As this Court noted in *Firestone*, the law of trusts requires that courts take a trustee's conflict of interests with a beneficiary into account. 489 U.S. at 115 (citing *Restatement (Second) of Trusts* § 187 cmt. d (1959)). Since *Firestone* was decided, the *Restatement (Third) of Trusts* has further clarified that "while it is permissible for a trustee to act under a structural conflict of interest, its discretionary decisions 'will be subject to especially careful scrutiny.'" *Post*, 501 F.3d at 162 (quoting *Restatement (Third) of Trusts* § 37 cmt. f(1) (2003)).

"Trust law proscribes conflicts of interest because of the significant danger that improper motivations *might* affect a conflicted fiduciary's decision-making, not because proof of a conflict establishes causation." Donald T. Bogan & Benjamin Fu, *ERISA*: *No Further Inquiry into Conflicted Plan Administrator Claim Denials*, 58 Okla. L. Rev. 637, 662 (2005); John H. Langbein, *Questioning the Trust Law Duty of Loyalty: Sole Interest or Best Interest?*, 114 Yale L.J. 929, 931 (2005) ("Courts invalidate a conflicted transaction without regard to its merits — 'not because there is fraud, but because there may be fraud.' '[E]quity deems it better to . . . strike down all disloyal acts, rather than attempt to separate the harmless and the harmful by permitting the trustee to justify his representation of two interests.'") (alteration in original) (internal citations and quotation marks omitted). Under well-established canons of trust law, trustees operating under a self-dealing conflict of interest are subjected to the "no-further-inquiry" rule, relieving beneficiaries of the

evidentiary burden of proving causation. *See, e.g.*, *Wendt v. Fischer*, 154 N.E. 303, 304 (N.Y. 1926) (Cardozo, J.). Furthermore, under the "no-further-inquiry" rule, once a conflict of interest is demonstrated, courts presume that the conflict of interest influenced the trustee's decision-making and hold that the presumption of taint is irrebuttable. *See, e.g.*, *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928) (Cardozo, J.).

Petitioners' arguments are also contrary to ERISA's language. The statute expressly requires a fiduciary – defined as anyone who "exercises any discretionary authority or discretionary control respecting management of [a] plan or exercises any authority or control respecting management or disposition of its assets," 29 U.S.C. § 1002(21)(A)(i) – to provide a "full and *fair* review" of claim denials, 29 U.S.C. § 1133(2) (emphasis added). Turning a blind eye or conferring a bare nod in the general direction of a structural conflict of interest does not comport with the clear statutory mandate.

D. The Presence Of Additional Factors Warrants Heightened Concern For Bias And Hence Closer Review Of Decisions By A Dual-Role Insurer/Administrator.

There are a variety of additional factors suggestive of bias in decision-making by a dual-role insurer/administrator the presence of which will indicate the need for closer review. *See* Kathryn Kennedy, *Judicial Standard of Review in ERISA Benefit Claim* Cases, 50 Am. U. L. Rev. 1083, 1155 (2001) (collecting cases). Where the claim

administrator's compensation is affected by approval/denial rates or metrics derived from approval and/or denial rates, there will be subtle and not-so-subtle pressures for denial in all but the clearest cases of entitlement. *See generally* John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 Nw. U. L. Rev. 1315 (2007). Performance bonuses are, after all, a significant incentive for desired conduct, and where the bonus (or other compensation) derives from denial of claims, there must be error favoring denial. Similarly, a claims administrator who is an at-will employee likely faces, or at least perceives, pressure to deny claims.

Patterns of denial of claims that disregard or devalue assessments of treating healthcare providers are most assuredly suggestive of bias. Such a pattern may indicate that factors other than legitimacy of the claim is affecting the claims administration decisions, as may a preference for the evaluations of insurer-retained healthcare providers. Of course, where the administrative file itself demonstrates or evidences bias, the decision should be subject to closer and more skeptical review than otherwise. These factors help illustrate the many ways in which petitioners' arguments run counter to the language and purpose of ERISA, defy common sense and human nature, and invite an altogether untenable result.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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