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 AND COMPANY,

Petitioners,

– v. –

WANDA GLENN,

Respondent.

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

BRIEF *AMICUS CURIAE* OF LEGAL AID SOCIETY— EMPLOYMENT LAW CENTER

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March 31, 2008

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STATEMENT OF INTEREST[1]

The Legal Aid Society - Employment Law Center ("LAS-ELC") is a non-profit public interest law firm whose mission is to protect, preserve, and advance the workplace rights of individuals from traditionally under-represented communities. Since 1970, the LAS-ELC has represented plaintiffs in cases involving the rights of employees in the workplace, particularly those cases of special import to communities of color, women, recent immigrants, individuals with disabilities, and the working poor. Employee benefits are crucial to low-wage workers because they do not have financial resources of their own to obtain medical benefits or pay living expenses in the event of disability.

The LAS-ELC has appeared before this Court on numerous occasions both as counsel for plaintiffs, *see National Railroad Passenger Corp. v. Morgan*, 536 U.S. 101 (2002); *U.S. Airways, Inc. v. Barnett*, 535 U.S. 391 (2002); and *California Federal Savings & Loan Ass'n v. Guerra*, 479 U.S. 272 (1987) (counsel for real party in interest), as well as

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[1]Pursuant to Supreme Court Rule 37.6, amicus states that no person or entity other than the amicus curiae, and their undersigned counsel made a monetary contribution to the preparation or submission of this brief. No attorney for any party authored this brief in whole or in part. Written consent to the filing of this brief has been obtained from the parties in accordance with Supreme Court Rule 37.3(a). Copies of the consent letters have been filed with the Clerk.

in an amicus curiae capacity, *see, e.g.*, *U.S. v. Virginia*, 518 U.S. 515 (1996); *Harris v. Forklift Systems*, *Inc.*, 510 U.S. 17 (1993); *International Union, UAW v. Johnson Controls*, *Inc.*, 499 U.S. 187 (1991); *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989); *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987); *Meritor Savings Bank v. Vinson*, 477 U.S. 57 (1986). The LAS-ELC has a strong interest in protecting the employee benefit rights of its clients.

SUMMARY OF ARGUMENT

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), this Court determined that where the plan document gives the administrator discretionary authority to determine eligibility for benefits and interpret the plan, but the administrator has a conflict of interest, that conflict "must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115, *quoting* Restatement (Second) of Trusts § 187, cmt. d (1959) (alteration in original).

The first question presented by this case, "Whether an administrator that both evaluates and pays claims under a plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C.1001 *et seq.*, is operating under a conflict of interest that must be weighed on judicial review of a benefit determination," has been answered in the affirmative by a substantial majority of circuits. *See, e.g.*, *Post v. Hartford Ins. Co.*, 501 F.3d 154, 162 (3d Cir. 2007) ("We have

long held that a structural conflict arises when the administrator has a non-trivial financial incentive to act against the interests of the beneficiaries.")

Only two circuits, the First and the Seventh, have determined that a financial conflict of interest is no conflict at all. *See Mers v. Marriott Int'l Group Acc. Death and Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998), *cert. denied*, 525 U.S. 947 (1998); *Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan,* 402 F.3d 67, 74-75 (1st Cir. 2005). [2] The approach of these two circuits stands in opposition to the Supreme Court's previous statements on this subject and should be rejected. *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 n. 15 (2002) ("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."); *see also Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 965 n.5 (9th Cir. 2006) (en banc) (noting that although the *Firestone* Court "did not catalogue the full range of types of conflicts of interest, . . . it suggested that a conflict exists when a plan administrator (which acts as a fiduciary toward the plan participants, who are beneficiaries) is also the sole source of funding for an unfunded

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[2] *Cf. Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996) (acknowledging the presence of the financial conflict of interest, although not weighing the conflict unless the participant proves it tainted the decision).

plan; this was Firestone's situation"). Further, the Solicitor General agrees that a financial conflict of interest is an inherent conflict of interest and that this "type of conflict generally warrants careful scrutiny in the trust context, even in the absence of evidence that the plan administrator actually acted because of its financial self-interest." Solicitor's Cert. Br. at 13-14.

The second question presented – "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?" – is one that has befuddled the lower courts. As noted by the Third Circuit, "Since *Firestone*, courts have struggled to give effect to this delphic statement, and to determine both what constitutes a conflict of interest and how a conflict should affect the scrutiny of an administrator's decision to deny benefits." *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 383 (3d Cir. 2000). While many circuits have employed some variation on the "sliding scale" approach, which reduces the deference afforded to the conflicted administrator's decision as the "weight" of the conflict of interest increases, this approach is much-criticized – even by the circuits employing it – as not providing sufficient guidance to the lower courts to enable judicial consistency. As the Seventh Circuit has noted, the fundamental unanswered question in the sliding scale approach is: "How *much* does [a conflict of interest] weigh? [One court] recently

concluded that it can't weigh very much without exceeding the judicial capacity to tailor standards of review. Judges understand deferential and non-deferential review, but intermediate variations blur into one another without promoting understanding or consistent adjudication." *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999).

Lower courts, plan participants, and plan administrators will all benefit from clear direction from this Court on how to weigh a dual-role administrator's conflict of interest. Just as in *Firestone,* the Court should again look to trust law to adopt the standard suggested by Respondent: when a "beneficiary serves as a trustee or when other conflict-of-interest situations exist, the conduct of the trustee in the administration of the trust will be subject to especially careful scrutiny." Restatement (Third) of Trusts § 37, cmt. f(1). Additionally, where other factors besides the inherent financial conflict of interest are present that demonstrate biased decision-making by the administrator, such as a history of denying meritorious claims, reliance on the reports of biased medical reviewers, violations of the Department of Labor's regulations in the claims review process, or inconsistent reasons for denying a claim, the Court should hold that the decision is entitled to very little deference, if any.

ARGUMENT

I. INTRODUCTION

Most circuits have held that a financial conflict of interest is a conflict that must be weighed in determining whether there has been an abuse of discretion, in accordance with *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). Because two circuits have clearly rejected this analysis, the Court should clarify that a financial conflict of interest, where the administrator both makes the claims decision and pays for the benefits, is indeed a conflict of interest and must be taken into account.

Once the Court confirms that threshold conflict of interest, the Court should provide concrete guidance to the lower courts to enable them to weigh that conflict pursuant to *Firestone*. Specifically, the Court should hold that when a "beneficiary serves as a trustee or when other conflict-of-interest situations exist, the conduct of the trustee in the administration of the trust will be subject to especially careful scrutiny." Restatement (Third) of Trusts § 37, cmt. f(1). The Court should provide further guidance by outlining several additional factors that automatically alter the standard of review, such that if any of those factors are present, the conflicted administrator's decision receives little, if any, deference

II. *FIRESTONE* MANDATES THAT COURTS "MUST" WEIGH A CONFLICT OF INTEREST AS A FACTOR IN EXAMINING THE CLAIM FIDUCIARY'S DECISION.

Citing trust law principles, this Court in *Firestone* held that the default standard of review of benefits decisions under ERISA plans is de novo except where a plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or interpret the terms of the plan. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). If the plan grants such discretionary authority to the plan administrator or fiduciary, then the district court will review a claim denial under the "abuse of discretion" standard. *Id.*

In the ERISA context, the courts have adopted different formulations of the abuse of discretion standard of review, which is sometimes referred to as the "arbitrary and capricious" standard.[3] The Seventh Circuit has gone so far as to describe this standard as similar to a "loud guffaw" test:

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[3] Many courts have mistakenly treated "arbitrary and capricious" and "abuse of discretion" review as the same. *See, e.g.*, *Taft v. Equitable Life Assur. Soc.*, 9 F.3d 1469, 1471 (9th Cir. 1993) ("abuse of discretion" standard and "arbitrary and capricious" standard the same). *See generally* Petitioner's Br. § II A.

> Although it is an overstatement to say that a decision is not arbitrary or capricious whenever a court can review the reasons stated for the decision without a loud guffaw, it is not much of an overstatement. The arbitrary or capricious standard is the least demanding form of judicial review of administrative action. Any questions of judgment are left to the agency, or here to the administrator of the Plan.

Pokratz v. Jones Dairy Farm, 771 F.2d 206, 209 (7th Cir. 1985), *overruled on other grounds by Firestone*, 489 U.S. at 115. *See also Rud v. Liberty Life Assur. Co. of Boston*, 438 F.3d 772, 773 (7th Cir. 2006) (insurer's decision "was not so off the wall that it could be adjudged 'arbitrary and capricious.'") *But see Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994) (cautioning that courts must not act as "a rubber stamp" under abuse of discretion standard).

In conducting a de novo review, "the district court considers a denial-of-benefits challenge afresh, without deferring to the [administrator's] interpretation of the plan." *Allen v. Adage, Inc.*, 967 F.2d 695, 697 (1st Cir. 1992). *See also Perry v. Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990) (de novo review means a review "without deference to the decision or any presumption of correctness").

Most importantly for the present case, the *Firestone* Court also stated that "if a benefit plan gives discretion to an administrator or fiduciary

who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115, *quoting* Restatement (Second) of Trusts § 187, cmt. d (1959) (alteration in original). More recently, this Court has acknowledged the need for courts to scrutinize decisions made by conflicted plan administrators:

> An issue implicated by this case but requiring no resolution is the degree to which a plan provision for unfettered discretion in benefit determinations guarantees truly deferential review. 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. That last observation was underscored only two Terms ago in *Pegram v. Herdrich,* 530 U.S. 211, 120 S. Ct. 2143, 147 L.Ed.2d 164 (2000), when we again noted the potential for conflict when an HMO makes decisions about appropriate treatment, see *id.,* at 219-220, 120 S. Ct. 2143. It 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).

Thus, this Court's precedents require that where a conflict of interest exists, courts must take that conflict into account when deciding whether

there has been an abuse of discretion. The lower courts, however, have struggled with the issues of what is a conflict of interest and, once identified, how that conflict is weighed.

III. UNDER *FIRESTONE* AND TRUST LAW, COURTS MUST WEIGH A FINANCIAL CONFLICT OF INTEREST IN REVIEWING A CLAIM DENIAL.

Petitioner presents the question of "[w]hether an administrator that both evaluates and pays claims under a plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C.1001 *et seq.*, is operating under a conflict of interest that must be weighed on judicial review of a benefit determination." The answer is yes.

Where, as in this case, an ERISA plan fiduciary both determines eligibility for benefits and pays those benefits, most circuits acknowledge that there is an inherent financial conflict of interest. *See, e.g.*, *Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996) (acknowledging the presence of the financial conflict of interest, although not weighing the conflict unless the participant proves it tainted the decision); *Post v. Hartford Ins. Co.*, 501 F.3d 154, 162 (3d Cir. 2007) ("We have long held that a structural conflict arises when the administrator has a non-trivial financial incentive to act against the interests of the beneficiaries."); *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 233 (4th Cir. 1997); *Robinson v. Aetna Life Ins. Co.*, 443 F.3d 389, 395

(5th Cir. 2006); *Killian v. Healthsource Provident Adm'rs, Inc.*, 152 F.3d 514, 521 (6th Cir. 1998) (holding that where the administrator also funds the plan, there exists "an actual, readily apparent conflict," rather than a merely potential conflict because "it incurs a direct expense as a result of the allowance of benefits, and it benefits directly from the denial or discontinuation of benefits"); *Barnhart v. Unum Life Ins. Co. of Am.*, 179 F.3d 583, 588 (8th Cir. 1999); *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 965-66 (9th Cir. 2006) (en banc) ("On the one hand, such an administrator is responsible for administering the plan so that those who deserve benefits receive them. On the other hand, such an administrator has an incentive to pay as little in benefits as possible to plan participants because the less money the insurer pays out, the more money it retains in its own coffers."); *Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997, 1003 (10th Cir. 2004), *cert. denied*, 544 U.S. 1026 (2005); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566-68 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991) ("Because an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business.").

In his brief in support of granting the Petition for Certiorari, the Solicitor General also agrees that a financial conflict of interest is an inherent conflict of interest. Solicitor's Cert. Br. at 13. The Solicitor noted that because every claims decision made by a dual-role administrator affects its bottom line,

"[t]hat type of conflict generally warrants careful scrutiny in the trust context, even in the absence of evidence that the plan administrator actually acted because of its financial self-interest." *Id.* at 13-14. The Department of Labor predicted that ERISA plan fiduciaries and administrators would deny more than 42 million claims in 2002. *See* 65 Fed. Reg. 70246, 70263 (Nov. 21, 2000). For-profit insurance companies cannot avoid taking into consideration the potential liability represented by the aggregate of these denied claims.

The Seventh and First Circuits, however, hold that an insurer acting as a dual-role administrator has only a potential conflict and the insurer is presumed to be neutral. *Mers v. Marriott Int'l Group Acc. Death and Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998), *cert. denied*, 525 U.S. 947 (1998); *Wright* v. *R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005). In *Mers*, the Seventh Circuit found that no conflict existed because the insurer was a "Fortune 500" company and the financial impact of granting the particular benefit sought in the instant case was minuscule. 144 F.3d at 1020-21. Following the Seventh Circuit's analysis to its logical conclusion means an insurer, which has billions of dollars in assets, would never be deemed to have a financial incentive to deny a claim, because no single disability claim could possibly be large in comparison. This view ignores the reality that the accumulation of claim payments determines any insurer's bottom line. Indeed, the First Circuit has recently expressed reservations about its rejection

of a financial conflict of interest as being a conflict that alters the standard of review, calling its position "increasingly difficult to defend" in light of other circuits' analyses of the issue. *Denmark v. Liberty Life Assur. Co. of Boston*, 481 F.3d 16, 31 (1st Cir. 2007).

Moreover, the Seventh Circuit's approach is also based on the presumption that courts should not rewrite the terms of a contract. *See Rud v. Liberty Life Life Assur. Co. of Boston*, 438 F.3d 772, 775-77 (7th Cir. 2006). The Seventh Circuit's fundamental error is to view ERISA merely as a part of contract law, rather than as a statute based on trust law. *Id.* at 776 (assuming that an insurer would make adverse benefit decision out of financial self-interest "would destabilize large reaches of contract law, of which ERISA is, after all, a part . . . ."). However, this Court has already determined that trust law, not contract law, applies in these cases. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (1989). *Rud* ignores this precedent, and even suggests that "*Firestone* goes too far" by interfering with contract rights. 438 F.3d at 776.

Viewed from the perspective of trust law, this Court has stated that where the fiduciary has a financial interest in the claims decision, the "fiduciary capacity [is] necessarily compromised." *Pegram v. Herdrich*, 530 U.S. 211, 227 (2000). *See also* Restatement (Third) of Trusts § 37 cmt. f(1) (when trustee has a conflict of interest, "the conduct of the trustee in the administration of the trust will be subject to especially careful scrutiny").

The financial conflict of interest is significant because "insurance companies have an active incentive to deny close claims in order to keep costs down and keep themselves competitive." *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388 (3d Cir. 2000); *see also Fought*, 379 F.3d at 1006. The common law of trusts assumes that "[a] conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries." *Brown*, 898 F.2d at 1565. As the Third Circuit recently noted,

> The Second Restatement, on which the Supreme Court relied in *Firestone,* defines a "conflict" as merely "an interest in the trustee conflicting with that of the beneficiaries." Restatement (Second) of Trusts § 187 cmt. d (1959). This statement is worded broadly—almost to the point of being tautological—but it applies by its own terms to a situation in which the administrator has an interest (*e.g.,* in profit or a better bottom line) that is adverse to the interests of beneficiaries seeking payment.

Post, 501 F.3d at 162-63. Therefore, an insurance company that decides benefit claims and pays benefits from its own assets has an inherent conflict of interest that warrants especially careful scrutiny by a court reviewing a claim denial.

IV. THE MAJORITY OF CIRCUITS EMPLOY "SLIDING SCALE" TESTS TO WEIGH CONFLICTS OF INTEREST. THE LOWER COURTS NEED FURTHER GUIDANCE ON HOW TO ACCOUNT FOR CONFLICTS OF INTEREST.

The Court also granted certiorari on the following question suggested by the Solicitor General: "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?" A structural financial conflict of interest should automatically reduce the deference afforded to the conflicted administrator, and the Court should outline several other specific factors, *see* Section V, below, to give concrete guidance on what other types of evidence show that a conflict of interest may have tainted the administrator's decision and how to reduce the deference afforded to the conflicted administrator.

The lower courts are in need of clear guidance on this issue because, while most circuits apply some form of the "sliding scale" test, they have been unable to articulate what that means, and still others apply a standard other than the "sliding scale." After *Firestone*, the lower courts have adopted essentially four different approaches to "weighing" a claim fiduciary's conflict of interest in the review of a benefit claim denial: "sliding scale" (1st, 3rd, 4th, 5th, 6th, 7th, 8th, and 10th Circuits);

the credibility determination with guiding factors (9th Circuit); "smoking gun" (2nd Circuit); and burden shifting (11th Circuit).[4] The standards of the Ninth and Eleventh Circuits best account for a dual-role administrator's conflicts of interest, but, as explained below, still need further clarification to result in consistent adjudication.

A. The Sliding Scale Test.

The sliding scale test

> grants the administrator deference in accordance with the level of conflict. Thus, if the level of conflict is slight, most of the administrator's deference remains intact, and the court applies something similar to traditional arbitrary and capricious review; conversely, if the level of conflict is high, then most of its discretion is stripped away.

Post v. Hartford Ins. Co., 501 F.3d 154, 161 (3d Cir. 2007).

Most circuits that have adopted the sliding scale test have not given the district courts enough

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[4]The D.C. Circuit has not yet adopted an approach after *Firestone*. *See, e.g.*, *Wagener v. SBC Pension Benefit Plan-Non Bargained Program*, 407 F.3d 395, 402 (D.C. Cir. 2005) (acknowledging a circuit split on the issue and declining to adopt a position where the plaintiff would prevail under any standard of review).

guidance as to how to apply the sliding scale metaphor. Indeed, half of the circuits that have adopted the sliding scale have explicitly expressed reservations for this reason. *See Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999) ("How *much* does [a conflict of interest] weigh? [One court] recently concluded that it can't weigh very much without exceeding the judicial capacity to tailor standards of review. Judges understand deferential and non-deferential review, but intermediate variations blur into one another without promoting understanding or consistent adjudication."); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000) (sliding scale is "intellectually unsatisfying, or at least discomforting . . . [for] it is not clear how the process required by the typical arbitrary and capricious review changes."); *Barnhart v. Unum Life Ins. Co.*, 179 F.3d 583, 589 n.9 (8th Cir. 1999) (sliding scale standard "presents a considerable hurdle for plaintiffs. Logically, a plaintiff who can show that a conflict of interest or serious procedural irregularity caused a serious breach of the administrator's fiduciary duty will more than likely have substantial evidence showing that the fiduciary's decision was arbitrary and capricious."); *Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997, 1004 (10th Cir. 2004), *cert. denied*, 544 U.S. 1026 (2005) ("To say that there is a sliding scale of deference, however, merely begs the question: *how much* less deference ought a reviewing court afford? Our past opinions do not clearly address this question. . . . Our failure to articulate clearly the requirements of a less deferential arbitrary and

capricious standard has left district courts in this circuit without direction and has encouraged litigation.").

In practice, the sliding scale too often results in untempered deferential review of decisions made by conflicted fiduciaries because courts have no guidance as to what standard of review to apply that is less deferential than abuse of discretion review but not as rigorous as de novo review. *See, e.g.*, *Nolan v. Heald College*, 2007 WL 878946, *12-13 (N.D. Cal. Mar. 12, 2007) (court stated that it properly weighed MetLife's structural conflict of interest without elaborating on how it weighed that conflict, then upheld the administrator's decision); *Schofield v. Metro. Life Ins. Co.*, 2006 WL 3359197, *3 (E.D. Cal. Nov. 20, 2006) (concluding that the court would review the administrator's decision with a "high degree of deference" despite presence of structural conflict of interest, and therefore upholding the administrator's decision); *Matos v. Lorillard Tobacco Co. Group Disability Ins. Plan*, 391 F. Supp. 2d 392, 398 (M.D.N.C. 2005) (stating that "Continental Casualty's dual role of plan administrator and plan insurer indeed creates such a conflict of interest necessitating the application of the sliding scale standard of review," then concluding that there had been no abuse of discretion without analysis of how the sliding scale affected the decision); *Brodish v. Federal Express Corp.*, 384 F. Supp.2d 827, 833 (D. Md. 2005) (explaining that defendant had a "mild" conflict of interest, but holding that there was no abuse of

discretion without explanation about the impact of the conflict).

Moreover, the courts have expressed discomfort at the unfair results when judicial hands are tied by the abuse of discretion standard. In *Brigham v. Sun Life of Canada*, 317 F.3d 72, 82, 86 (1st Cir. 2003), the First Circuit upheld an insurer's denial of disability benefits to a paraplegic under the abuse of discretion standard, but stated:

> [W]e confess considerable ambivalence about whether Brigham *should* be expected to return to the workforce . . . it seems counterintuitive that a paraplegic suffering serious muscle strain and pain, severely limited in his bodily functions, would not be deemed totally disabled. . . . [but] the undisputed facts of records do not permit us to find that Sun Life acted in an arbitrary or capricious manner in terminating appellant Brigham's benefits.

(emphasis in original).

First Circuit: While the First Circuit avoids using "sliding scale" terminology, it still employs a sliding scale test. It characterizes the lesser deference afforded to plan decisions influenced by a conflict of interest as being arbitrary and capricious review with "more bite." *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999) (holding that "fine gradations in phrasing are as likely to complicate as to refine the standard," and that the "essential

requirement of reasonableness has substantial bite itself"). In the First Circuit, if there is sufficient "bite," the scale can slide all the way to de novo review. *See Janeiro v. Urological Surgery Prof'l Ass'n*, 457 F.3d 130, 142 (1st Cir 2006) (applying the level of "bite" necessary to account for the severity of the conflict may require "no deference to the conflicted decisionmaker"). In criticizing the "more bite" approach, the Seventh Circuit aptly noted that courts using this standard of review "have never come up with an operational definition of 'more bite' or a specification of the appropriate circumstances for mastication." *Perlman*, 195 F.3d at 981.

Third Circuit: The Third Circuit explained that in its application of the sliding scale approach, the court "approximately calibrat[es] the intensity of our review to the intensity of the conflict." *Pinto*, 214 F.3d at 393. However, at the same time the court also acknowledged that the standard is "intellectually unsatisfying, or at least discomforting. . . . [for] it is not clear how the process required by the typical arbitrary and capricious review changes." *Id.* at 392. Recently, the court acknowledged that "[i]n the face of non-trivial evidence of procedural bias, the standard of review should be raised; the more difficult question is how much." *Post*, 501 F.3d at 165.

Fourth Circuit: The Fourth Circuit in *Elliot v. Sara Lee Corp.*, 190 F.3d 601, 605 (4th Cir. 1999), modified the abuse of discretion standard to the extent necessary to counteract any "influence

unduly resulting from the conflict." In *Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 233-34 (4th Cir. 1997), the court explained that "[t]he more incentive for the administrator or fiduciary to benefit itself by a certain interpretation of benefit eligibility or other plan terms, the more objectively reasonable the administrator or fiduciary's decision must be and the more substantial the evidence must be to support it." This explanation, however, only underscores the inevitable subjectivity that results in inconsistent adjudication under the sliding scale approach: the word "more" does not quantify how far down the scale a court should slide.

Fifth Circuit: In *Vega v. National Life Insurance Services*, 188 F.3d 287, 297 (5th Cir. 1999) (en banc), the Fifth Circuit reaffirmed that "[t]he greater the evidence of conflict on the part of the administrator, the less deferential our abuse of discretion standard will be." Again, the terms "greater" and "less" deference provide little guidance to the district courts for consistent adjudication.

Sixth Circuit: As articulated by the Sixth Circuit in the opinion below, district courts must discuss the role of the administrator's conflict of interest and give that conflict "weight," to determine whether the decision is the "result of a principled reasoning process." *Glenn v. MetLife*, 461 F.3d 660, 666, 674 (6th Cir. 2006), *cert. granted*, 128 S. Ct. 1117 (2008). Nonetheless, the court characterizes this weighted review as a

"highly deferential standard." *Id.*; *see also Borda v. Hardy, Lewis, Pollard & Page, P.C.*, 138 F.3d 1062, 1069 (6th Cir. 1998) (concluding that the fiduciary will be entitled to some deference, but that "application of the standard should be shaped by the circumstances of the inherent conflict of interest"). The instruction to "weigh" a conflict to "shape" judicial review while simultaneously applying a highly deferential standard is a contradiction in itself, and is an example of why further guidance is necessary.

Seventh Circuit: As quoted above, in an attempt to apply *Firestone's* instruction to weigh conflicts of interest as a factor in the standard of review, the Seventh Circuit noted the need for clarification on "how much" a conflict of interest should weigh. *Perlman*, 195 F.3d at 986. However, the Seventh Circuit also employs the sliding scale approach, despite questioning its ability to promote "understanding or consistent adjudication." *Id.*; *see also Chojnacki v. Georgia-Pacific Corp.*, 108 F.3d 810, 815 (7th Cir. 1997) ("The more serious the conflict, the less deferential our review becomes.")

Eighth Circuit: The Eighth Circuit determined in *Clapp v. Citibank N.A. Disability Plan*, 262 F.3d 820, 827 (8th Cir. 2001), that a court should give less deferential sliding-scale review if the claimant produces material probative evidence that a palpable conflict was connected to the administrator's decision so as to cause a serious breach of fiduciary obligation. Like other circuits, the Eighth Circuit acknowledges that there is an

inherent problem with this approach: if the plan participant has produced the required evidence to trigger a sliding scale review, the plan participant also likely would be able to receive a favorable result under the traditional abuse of discretion review. *Barnhart*, 179 F.3d at 589 n.9.

Tenth Circuit: In *Fought*, 379 F.3d at 1005, the en banc court revised its conflict of interest approach because it recognized that the lack of concrete guidance afforded to district courts on the issue resulted in judicial confusion. "To say that there is a sliding scale of deference, however, merely begs the question: *how much* less deference ought a reviewing court afford? Our past opinions in this area do not clearly address this question. . . . Our failure to articulate clearly the requirements of a less deferential arbitrary and capricious standard has left district courts in this circuit without direction and has encouraged litigation." *Id.* at 1005. The court ultimately adopted another variation of the sliding scale test. First, the court stated that courts should consider a "standard" conflict of interest, i.e., a financial conflict, in determining whether there has been an abuse of discretion. *Id.* Next, the court considers whether there is (1) an inherent financial conflict of interest; (2) a proven conflict of interest "or (3) when a serious procedural irregularity exists, and the plan administrator has denied coverage." *Id.* at 1006. If so, "an additional reduction in deference is appropriate" and the administrator bears the burden of proving that its decision is reasonable and based on substantial evidence. *Id.* Although

the *Fought* court adopted a test that provides more guidance than the Tenth Circuit's prior approach, the court's new test still does not provide clear guidance as to how much a district court should reduce deference to a conflicted administrator.

B. The Smoking Gun Test.

In the Second Circuit, the plan participant must produce "smoking gun" evidence that proves that the administrator's decision was infected by the conflict of interest in order to receive anything but untempered abuse of discretion review. *Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1259 (2d Cir. 1996) (holding that plaintiffs have the burden of proving that the conflict of interest affected the administrator's decision). This standard is in direct conflict to *Firestone's* instruction that a conflict of interest 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); *see DeFelice v. Am. Int'l Life Assur. Co.*, 112 F.3d 61, 66 n. 3 (2d Cir. 1997) (criticizing *Sullivan* for ignoring *Firestone* by minimizing the effect of administrator's conflict of interest). In addition, because this standard requires the plaintiffs to *prove* that an administrator acted on a conflict, it places plaintiffs in an untenable position: on the one hand, plaintiffs bear the burden of proof of producing concrete evidence of conflicted decision-making, but on the other hand, plaintiffs are only permitted to seek evidence outside of the claims record where the plaintiff can demonstrate the

presence of "good cause" *in* the claims record to warrant discovery. *See Paese v. Hartford Life & Accident Ins. Co.*, 449 F.3d 435, 441 (2d. Cir. 2006).

Beneficiaries have little chance of finding a "smoking gun" to prove that the administrator acted on a conflict. *See, e.g.*, *Pinto*, 214 F.3d at 379. ("Our rule is also informed by the understanding that 'smoking gun' direct evidence of purposeful bias is rare in these cases so that, without more searching review, benefits decisions will be virtually immunized."). The Ninth Circuit rejected its previous standard requiring participants to produce such evidence, stating "[t]hat approach wrongly aligns incentives. Instead of being encouraged affirmatively to demonstrate their impartiality and the reasonableness of their decisions, plan administrators are rewarded for suppressing dissent and denying claims with as little explanation as possible." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967 (9th Cir. 2006) (en banc). Consequently, it should not be the burden of the beneficiary "'to show that the fiduciary succumbed to this temptation, that he acted in bad faith, that he gained an advantage, fair or unfair, that the beneficiary is harmed.'" *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1565 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991), quoting *Fulton Nat'l Bank v. Tate*, 363 F.2d 562, 571-72 (5th Cir. 1966).

C. The Burden Shifting Test.

In the Eleventh Circuit, where there is a financial conflict of interest the court weighs the conflict by applying a de novo standard of review to the benefits decision, and then determines whether the fiduciary or administrator can demonstrate that its decision was not tainted by its financial self-interest. *Brown*, 898 F.2d at 1566-68. Under this approach, a court weighs the conflict of interest by determining whether, on de novo review, the administrator's decision is "wrong." *Id.* at 1567 n.12. If the decision is correct on de novo review, then the administrator's decision stands. If the decision would be wrong under a de novo review, the court further examines the conflict of interest. The direction to conduct a de novo review of the merits where there is a financial conflict of interest provides clear guidance to the lower courts for *how* to weigh the conflict, which is the very question posed time and time again by the sliding scale circuits.

Moreover, the Eleventh Circuit's standard conserves judicial resources, because it is only in those cases where the fiduciary's decision is wrong on de novo review that the court also must examine the seriousness of the conflict of interest and determine whether the fiduciary's decision is entitled to deference. If this Court adopts the Eleventh Circuit's approach of reviewing a benefits claim de novo where a financial conflict of interest is present unless the fiduciary can prove that the conflict did not affect the decision, most discovery

and motion practice regarding the standard of review would also be eliminated, and ERISA benefit litigation would be substantially streamlined. *See, e.g.*, *Aguilar v. New United Motor Mfg., Inc. Disability Ins. Income Plan*, 2005 WL 2137784, *1 (N.D. Cal. Aug. 30, 2005) (where plan contained no grant of discretion, parties and court agreed at pre-trial conference that standard of review would be de novo; court did not consider evidence outside of the claim record and, following bench trial, ruled in favor of defendant); *McCoy v. Fed. Ins. Co.*, 7 F. Supp. 2d 1134, 1137 (E.D. Wash. 1998) (plan did not contain grant of discretion; case decided on motion for summary judgment without considering evidence outside of claim record).

D. The Credibility Determination with Clarifying Factors Test.

In *Abatie,* Ninth Circuit articulated its approach as "abuse of discretion review, tempered by skepticism commensurate with the plan administrator's conflict of interest." 458 F.3d at 959. Consistent with *Firestone*, 489 U.S. at 115, the Ninth Circuit instructed district courts to weigh any conflict of interest as a factor in abuse of discretion review:

> [W]eighing a conflict of interest as a factor in abuse of discretion review requires a case-by-case balance. . . . A district court, when faced with all the facts and circumstances, must decide in each case how much or how little to credit the plan administrator's

> reason for denying insurance coverage. An egregious conflict may weigh more heavily (that is, may cause the court to find an abuse of discretion more readily) than a minor, technical conflict might.

Abatie, 458 F.3d at 967, 968.

Although the Ninth Circuit acknowledged that its test was "substantially similar" to the "sliding scale" test used by the majority of Circuits, *id.* at 967, the court rejected the "sliding scale" metaphor and instead chose credibility determinations as a more apt analogy:

> [T]rial courts are familiar with the process of weighing a conflict of interest. For example, in a bench trial the court must decide how much weight to give to a witness' testimony in the face of some evidence of bias. What the district court is doing in an ERISA benefits denial case is making something akin to a credibility determination about the insurance company's or plan administrator's reason for denying coverage under a particular plan and a particular set of medical and other records.

Id. at 969. Just as evidence of bias can undercut the credibility of a witness' testimony, evidence of a conflict of interest may belie an insurance company's stated reasons for denying a claim. *See Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052 (7th Cir. 1987) (Posner,

J.) (when trustees "have a serious conflict of interest, the proper deference to give their decisions may be slight, even zero; the decision if wrong may be unreasonable").

The *Abatie* decision responds to criticism of the sliding scale test as too vague by supplying much-needed guidance and examples to the district courts. The Ninth Circuit's approach is an improvement upon the sliding scale test because it provides categories of evidence that the courts should consider in deciding whether a claims fiduciary was influenced by a conflict of interest and how different types of conflicts should affect the judicial standard of review.

In *Abatie*, the Ninth Circuit listed numerous examples of evidence that might cause a court to weigh a conflict more heavily: "evidence of malice, of self-dealing, or of a parsimonious claims-granting history." 458 F.3d at 968. Further examples include where "the administrator provides inconsistent reasons for denial; fails adequately to investigate a claim or ask the plaintiff for necessary evidence; fails to credit a claimant's reliable evidence; or has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record." *Id.* at 968-69.

The Ninth Circuit also suggested factors that may ameliorate a fiduciary's conflict of interest: the administrator could demonstrate that it used

"truly independent medical examiners or a neutral, independent review process; that its employees do not have incentives to deny claims; that its interpretations of the plan have been consistent among patients; or that it has minimized any potential financial gain through structure of its business (for example, through a retroactive payment system)." *Id.* at 969 n. 7. Conversely, if a participant can show that a claims fiduciary failed to take these precautions, then a court may weigh the conflict more heavily.

The *Abatie* court's approach also gives district courts the flexibility necessary to account for the variety of administrative schemes found in ERISA plans. Although an insurance company acts as claims administrator and pays disability benefits out of its own assets under most disability plans (including the plan in the present case), different arrangements which present less risk of financial conflicts of interest are common in other types of ERISA plans.

For example, ERISA requires that pension plan assets be held in trust[5] and pension plans are

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[5]"ERISA requires a plan's combined assets to be held in trust and legally owned by the plan trustees." *LaRue v. DeWolff, Boberg & Associates, Inc.,* —U.S.—, 128 S. Ct. 1020, 1029 (2008) (Thomas, J. concurring), *citing* ERISA § 403(a), 29 U.S.C. § 1103(a). ERISA's trust requirement does not apply to plans providing benefits through insurance policies. ERISA § 403(b)(1); 29 U.S.C. § 1103(b)(1).

typically administered by a plan committee composed of company employees. Since the pension trust assets can "never inure to the benefit of any employer," ERISA § 403(c)(1), 29 U.S.C. § 1103(c)(1), the typical pension plan's administrative scheme poses less risk of financial conflicts of interest than an insurance company's incentive to minimize claims payments from its own assets. If the entity making the claims decision is not responsible for paying benefits, it is less likely to have a financial conflict of interest. *See Pinto*, 214 F.3d at 383; *see also Fought*, 379 F.3d at 1005.[6]

The credibility determination required by *Abatie* permits the courts to make a common-sense decision as to whether the claims fiduciary acted properly. The courts have heard insurance disputes similar to the present case for centuries and are experienced in deciding whether an insurance coverage denial is justified or in bad faith. The fact that the present case arose in the

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[6]However, as noted by the concurring opinion in *Abatie*, "A so-called independent administrator may have much more of an incentive to decide against claimants than an insurance company spending 'its own money.' Independent administrators may want to show how tough they are on claims to better market their services to self-insured employers." 458 F.3d at 977 (Kleinfeld, J. concurring). Therefore, courts need to consider a third-party administrator's compensation arrangements and incentives before assuming that a third-party administrator has no financial self-interest.

context of an ERISA plan does not change the fact that the underlying dispute is an insurance coverage claim. *See generally* NAIC Amicus Br.

V. THIS COURT SHOULD IMPROVE UPON *ABATIE* BY ADOPTING THE RESTATEMENT OF TRUST'S "ESPECIALLY CAREFUL SCRUTINY" TEST AND PROVIDING THE LOWER COURTS WITH ADDITIONAL GUIDANCE SPECIFIC TO ERISA CLAIMS.

The *Abatie* court's credibility determination test is an improvement upon the "sliding scale" standard because the Ninth Circuit gave specific examples of evidence showing a serious conflict of interest to guide the lower courts. *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 968-69 (9th Cir. 2006) (en banc). Nevertheless, the *Abatie* court's holding falls short of the trust law standard for a conflicted fiduciary. Instead, this Court should adopt the standard suggested by Restatement (Third) of Trusts for a dual-role administrator: when a "beneficiary serves as a trustee or when other conflict-of-interest situations exist, the conduct of the trustee in the administration of the trust will be subject to especially careful scrutiny." § 37, cmt. f(1).[7]

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[7]The Eleventh Circuit's burden shifting test is the simplest and most efficient method for the courts to evaluate decisions made by dual-role administrators; however, some courts have criticized the test as being

(footnote continued...)

Amicus agrees with Respondent that the trust law requirement of "especially careful scrutiny" mandates closer scrutiny of a conflicted trustee's actions than the baseline requirement of reasonableness for an unconflicted trustee's actions. The reviewing court must satisfy itself that the conflict did not impermissibly affect the dual-role insurer's decision, whether consciously or unconsciously.

Although the "especially careful scrutiny" standard is appropriate as the default standard of review for a dual-role administrator, the courts should apply a stricter standard of review if there is additional evidence that the claim decision was tainted by a conflict of interest. As the Ninth Circuit did in *Abatie*, the Court should take this opportunity to provide the lower courts with

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(continued from previous page)
inconsistent with *Firestone*. *See Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 826 (10th Cir. 1996). However, if this Court decides otherwise, then the Eleventh Circuit's approach is best-suited for protecting the benefit rights of plan participants. *See* 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, 1334 (2007) ("The Supreme Court could, without confessing error in *Bruch*, materially reduce the scope of *Bruch's* mischief by resolving this conflict among the circuits in favor of the position of the Eleventh Circuit, insisting on de novo review despite contrary plan terms in cases involving conflicted decisionmaking.").

guidance as to factors that result in a stricter standard of review than "especially careful scrutiny."

In weighing evidence of a claims administrator's conflict of interest, the courts should consider "both structural and procedural factors." *Post v. Hartford Ins. Co.*, 501 F.3d 154, 162 (3d Cir. 2007), *citing Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 192-93 (3d Cir. 2000). Certain structural conflicts and procedural violations are so at odds with ERISA's requirement that administrators provide participants with a "full and fair review," ERISA § 503, 29 U.S.C. § 1133, that these factors should result in the courts giving little or no deference to the administrator's claim denial. *See, e.g.*, *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 511 F.3d 1206, 1216-17 (9th Cir. 2008) (noting that, under *Abatie*, the lower court should determine "the degree of deference (*if any*) it should accord MetLife's decision") (emphasis added).

Although the following list is not exhaustive, amicus believes that little or no judicial deference should be given to a dual-role administrator where any of these four factors is present.

A. The Courts Should Review the Claim Denial de Novo Where a Dual Role Administrator Violates the Secretary of Labor's Claim Procedure Regulations.

The courts should review de novo claim denials in cases where the administrator violates the

requirements contained in the Secretary of Labor's Claims Procedure Regulations, 29 C.F.R. § 2560.503-1, promulgated pursuant to ERISA § 503, 29 U.S.C. § 1133. The Regulations "set[] forth the minimum requirements for employee benefit plan procedures pertaining to claims for benefits, " 29 C.F.R. § 2560.503-1(a), in order to provide claimants with a "full and fair review" as required by 29 U.S.C. § 1133(2). Many of the rules set forth in the Regulations are also required to be included in the Summary Plan Description (SPD), the plan document which plan administrators are required to provide to plan participants. ERISA § 102, 29 U.S.C. § 1022 ("[t]he summary plan description shall contain . . . the procedures to be followed in presenting claims for benefits under the plan . . .").

A violation of the Regulations or the SPD is akin to a trustee violating the terms of the trust document. In such instances, the courts do not give any deference to the decisions of the trustee. For example, in *Valma M. Hanson Revocable Trust*, 779 N.E.2d 1218, 1220-23 (Ind. App. 2002), the court held that the beneficiaries had stated a cause of action in alleging that the trustee had violated the terms of the trust, rejecting the trustee's arguments that his actions were within his discretionary authority as trustee. Similarly, the Second Circuit and other circuits have held that a "deemed denial" of a benefit claim resulting from a claim fiduciary's failure to decide a claim within the time frame required by the Regulations and/or plan documents is not entitled to discretionary review. *Nichols v. Prudential Ins. Co. of Am.*, 406

F.3d 98, 109 (2d Cir. 2005). *See also Abatie*, 458 F.3d at 971 ("[F]lagrant" violations of the Department of Labor Regulations will result in *de novo* review."); *Jebian v. Hewlett-Packard Co. Employee Benefits Org. Income Prot. Plan*, 349 F.3d 1098, 1106-07 (9th Cir. 2003); *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 632-33 (10th Cir. 2003); *Gritzer v. CBS, Inc.*, 275 F.3d 291, 295 (3d Cir. 2002).

B. The Courts Should Give Little or No Deference to Claims Administrators Who Seek to Thwart Claimants by Changing Their Reasons for Denying a Claim.

In addition, the courts should give little or no deference to a claim denial where the claim fiduciary changes its reason for denying the claim. Many courts have criticized insurance companies that seek to frustrate claimants by changing the basis for a claim denial when the claimant presents evidence that the initial basis for denying the claim was wrong:

> [T]he fact that the claims administrator presented a new reason at the last minute bears on whether denial of the claim was the result of an impartial evaluation or was colored by MetLife's conflict of interest. After all, coming up with a new reason for rejecting the claim at the last minute suggests that the claim administrator may be casting about for an excuse to reject the claim rather than conducting an objective evaluation.

Saffon, 511 F.3d at 1215. *See also*, *Marolt v. Alliant Techsystems, Inc.*, 146 F.3d 617, 620 (8th Cir. 1998) ("We will not permit ERISA claimants denied the timely and specific explanation to which the law entitles them to be sandbagged by after-the-fact plan interpretations devised for purposes of litigation"); *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 799 (9th Cir. 1997) (de novo review where claim fiduciary provides inconsistent reasons for denial under former Ninth Circuit standard). The failure to provide a claim review process that permits the participant to respond to all of the administrator's reasons for rejecting his claim is adversarial conduct that warrants de novo review.

C. The Courts Should Give Little or No Deference to Claim Denials Based on Reports by Biased Medical Evaluators.

The court should give little if any deference to claim denials based on reports by biased physicians. As shown by *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), a key issue in disability benefit claims is the reliability of medical evidence. In *Nord*, this Court rejected adoption of the treating physician rule for ERISA disability benefit claims. *Id.* at 830-31. However, the Court expressed "concern that physicians repeatedly retained by benefits plans may have an incentive to make a finding of 'not disabled' in order to save their employers money and to preserve their own consulting arrangements." *Id.* at 1143 (quotation

omitted). For example, in *Hangarter v. Provident Life & Accident Insurance Co.*, 373 F.3d 998, 1011 (9th Cir. 2004), the court discounted the testimony of a physician hired by the insurer in a non-ERISA case where evidence obtained in discovery showed that the physician rejected insureds' disability claims in thirteen out of thirteen cases. In *Bennett v. Unum Life Insurance Co. of America,* 321 F. Supp. 2d 925, 933-36 (E.D. Tenn. 2004), the court recited evidence detailing how the insurer pressured claims adjusters and medical reviewers to deny claims to increase profits. *See also Abatie*, 458 F.3d at 969 n.7 ("a conflicted administrator, facing closer scrutiny, may find it advisable to bring forth affirmative evidence that any conflict did not influence its decision making process . . . [f]or example, the administrator might demonstrate that it used truly independent medical examiners . . . ."). If an administrator cannot show that its medical review process was neutral, the court should not be obligated to defer to its decision.

D. The Courts Should Give Little or No Deference to Claim Denials Where the Insurer Has a Parsimonious Claims Granting History.

Finally, where an insurer has a history of denying meritorious claims, courts should be permitted to review subsequent denied claims neutrally, on de novo review, rather than forced to defer to an administrator with a demonstrated bias. *See Abatie*, 458 F.3d at 968. For example, in *Radford Trust v. First Unum Life Insurance Co.*,

the court found that the case "is not the first time that First Unum has sought to avoid its contractual responsibilities, and an examination of cases involving First Unum . . . reveals a disturbing pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics." 321 F. Supp. 2d 226, 247 (D. Mass. 2004), *rev'd on other grounds*, 491 F.3d 21 (1st Cir. 2007); *see also* John H. Langbein, *Trust Law As Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 N.W. U. L. REV. 1315, 1317-21 (2007).

CONCLUSION

For the reasons stated above, this Court should uphold the decision below.

Respectfully submitted,

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APPENDIX

STATUTORY APPENDIX

29 C.F.R. § 2560.503-1(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.

ERISA § 102, 29 U.S.C. § 1022:

(a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

(b) The summary plan description shall contain the following information: The name and type of administration of the plan; in the case of a group health plan (as defined in section 1191b(a)(1) of this title), whether a health insurance issuer (as defined in section 1191b(b)(2) of this title) is responsible for the financing or administration (including payment of claims) of the plan and (if so) the name and address of such issuer; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees (if they are persons different

from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan including the office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights under this chapter and the Health Insurance Portability and Accountability Act of 1996 with respect to health benefits that are offered through a group health plan (as defined in section 1191b(a)(1) of this title) and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 1133 of this title).

ERISA § 403, 29 U.S.C. § 1103:

(a) Benefit plan assets to be held in trust; authority of trustees

Except as provided in subsection (b) of this section, all assets of an employee benefit plan shall be held in trust by one or more trustees. Such trustee or trustees shall be either named in the trust instrument or in the plan instrument described in section 1102(a) of this title or appointed by a person who is a named fiduciary, and upon acceptance of being named or appointed, the trustee or trustees shall have exclusive authority and discretion to manage and control the assets of the plan, except to the extent that--

(1) the plan expressly provides that the trustee or trustees are subject to the direction of a named fiduciary who is not a trustee, in which case the trustees shall be subject to proper directions of such fiduciary which are made in accordance with the terms of the plan and which are not contrary to this chapter, or

(2) authority to manage, acquire, or dispose of assets of the plan is delegated to one or more investment managers pursuant to section 1102(c)(3) of this title.

(b) Exceptions

The requirements of subsection (a) of this section shall not apply--

(1) to any assets of a plan which consist of insurance contracts or policies issued by an insurance company qualified to do business in a State;

(2) to any assets of such an insurance company or any assets of a plan which are held by such an insurance company;

(3) to a plan--

(A) some or all of the participants of which are employees described in section 401(c)(1) of Title 26; or

(B) which consists of one or more individual retirement accounts described in section 408 of Title 26;

to the extent that such plan's assets are held in one or more custodial accounts which qualify under section 401(f) or 408(h) of Title 26, whichever is applicable.

(4) to a plan which the Secretary exempts from the requirement of subsection (a) of this section and which is not subject to any of the following provisions of this chapter--

(A) part 2 of this subtitle,

(B) part 3 of this subtitle, or

(C) subchapter III of this chapter; or

(5) to a contract established and maintained under section 403(b) of Title 26 to the extent that the assets of the contract are held in one or more custodial accounts pursuant to section 403(b)(7) of Title 26.

(6) Any plan, fund or program under which an employer, all of whose stock is directly or indirectly owned by employees, former employees or their beneficiaries, proposes through an unfunded arrangement to compensate retired employees for benefits which were forfeited by such employees under a pension plan maintained by a former employer prior to the date such pension plan became subject to this chapter.

(c) Assets of plan not to inure to benefit of employer; allowable purposes of holding plan assets

(1) Except as provided in paragraph (2), (3), or (4) or subsection (d) of this section, or under sections 1342 and 1344 of this title (relating to termination of insured plans), or under section 420 of Title 26 (as in effect on August 17, 2006), the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan.

(2)(A) In the case of a contribution, or a payment of withdrawal liability under part 1 of subtitle E of subchapter III of this chapter--

(i) if such contribution or payment is made by an employer to a plan (other than a multiemployer plan) by a mistake of fact, paragraph (1) shall not prohibit the return of such contribution to the employer within one year after the payment of the contribution, and

(ii) if such contribution or payment is made by an employer to a multiemployer plan by a mistake of fact or law (other than a mistake relating to whether the plan is described in section 401(a) of Title 26 or the trust which is part of such plan is exempt from taxation under section 501(a) of Title 26), paragraph (1) shall not prohibit the return of such contribution or payment to the employer within 6 months after the plan administrator determines that the contribution was made by such a mistake.

(B) If a contribution is conditioned on initial qualification of the plan under section 401 or 403(a) of Title 26, and if the plan receives an adverse determination with respect to its initial qualification, then paragraph (1) shall not prohibit the return of such contribution to the employer within one year after such determination, but only if the application for the determination is made by the time prescribed by law for filing the employer's return for the taxable year in which such plan was adopted, or such later date as the Secretary of the Treasury may prescribe.

(C) If a contribution is conditioned upon the deductibility of the contribution under section 404

of Title 26, then, to the extent the deduction is disallowed, paragraph (1) shall not prohibit the return to the employer of such contribution (to the extent disallowed) within one year after the disallowance of the deduction.

(3) In the case of a withdrawal liability payment which has been determined to be an overpayment, paragraph (1) shall not prohibit the return of such payment to the employer within 6 months after the date of such determination.

(d) Termination of plan

(1) Upon termination of a pension plan to which section 1321 of this title does not apply at the time of termination and to which this part applies (other than a plan to which no employer contributions have been made) the assets of the plan shall be allocated in accordance with the provisions of section 1344 of this title, except as otherwise provided in regulations of the Secretary.

(2) The assets of a welfare plan which terminates shall be distributed in accordance with the terms of the plan, except as otherwise provided in regulations of the Secretary.

ERISA § 503, 29 U.S.C. § 1133:

In accordance with regulations of the Secretary, every employee benefit plan shall--

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) 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.

65 Fed. Reg. 70246, 70263 (Nov. 21, 2000):

The Department considered the following major actions that plans (or their service providers) would undertake to come into compliance with the regulation: revising processes, revising forms, modifying systems, and hiring or contracting where necessary. The Department assumed that all health and disability plans would have to revise processes and forms and modify systems to at least some degree and that some would hire personnel or contract for additional or different services in order to achieve compliance. [FN55]

FN55 This estimate is not intended to include the cost of developing new explanations of claims processes for inclusion in plan descriptions. The Department separately accounts for that cost as part of the estimated cost of its regulation governing the content of summary plan descriptions.

4. Ongoing Costs

In estimating the ongoing cost of various provisions, the Department considered the number of claims transactions to which they apply, the degree to which plans already comply in the course of normal business or in response to a state law or other mandate other than ERISA, and, to the degree that they do not, the likely cost of coming into compliance.
Claims volume was estimated by applying

estimated claiming rates for various types of claims to projected estimates of plan enrollment in 2002. To estimate the application of the regulation's various requirements to different types of benefit claims, it was necessary to separately estimate health, disability, pension, and other benefit claims volumes. With respect to health benefit claims, it was necessary to separately estimate urgent, pre-service, and post-service claims volume, and the number of denials that are based on clinical or medical judgments. With respect to disability claims, it was necessary to estimate short-term and long-term disability claims separately. The Department also accounted separately for costs associated with approved and denied claims and appeals. Table 4 summarizes estimated 2002 claims volume.

Table 4.--
Summary of Claims Volume, 2002

	Health (MMs)	Disability (000s)	Pension (000s)	Other (000s)
Claims	1,369.7	1,389.7	2,122.1	244.5
Approved	1,328.6	1,304.9	2,104.0	236.4
Denied	41.0	84.8	18.0	8.1
Appeals	0.4	31.6	1.8	0.8
Approved	0.3	6.5	0.9	0.4
Denied	0.1	25.1	0.9	0.4
Health claims (MMs)	1,369.7			
Urgent pre-service	1.2			
Routine pre-service	40.0			
Post-service	1,328.5			

Denied health claims (MMs)	41.0	.....	.....	.....
Clinical/scientific basis	14.5	.....	.....	.....
Other basis	26.5	.....	.....	.....
Disability claims (000s)	1,389.7	.....	.....	.....
Short-term	1,162.7	.....	.....	.....
Long-term	227.1	.....	.....	.....

The Department applied estimates of health and disability benefit claiming rates and claims mix to its estimates of enrollment in health and disability plans to produce its estimates of total claims volume. The Department estimated claims volume and mix in light of comments received in response to its proposed regulation and other data that provide reasonable proxies for private-sector employment-based health and disability benefit plans' claim patterns. For example, comments on the proposed regulation indicated health benefit claiming rates ranging from about 5 to 18 claims per individual per year. The average rate across all comments reporting rates was 9 claims per year, and surveys available to the Department reported rates of 6 [FN56] and 11 [FN57] claims per year. Many of these reported figures may omit some health benefit claims, such as dental claims, made by the same individuals under separate plans. The Department assumed that the health benefit claiming rates average 10 per covered individual, believing that this is consistent with comments received and other available information.

FN56 A published 1995 survey of 53 health insurers' claims systems by the Health Insurance Association of America.

FN57 A survey of 7 managed care organizations conducted and provided to the Department in response to its proposed regulation.
The Department similarly relied on comments received and other available data to assess health benefit claims denial and appeal rates and the mix of urgent, pre- and post-service claims. The Department assessed disability claiming rates and claims mix based on comments received (including information from the life insurance industry) and available data on the incidence of temporary and permanent disability in the working age population. [FN58]

FN58 Primarily, data from the National Center for Health Statistics and the Social Security Administration.
The Department separately considered the effect of each of the regulation's major provisions on each type of claim to which it applies. Based on its analysis, the Department attributed cost to the application of the regulation's notice, timeliness, disclosure, standard of review, and expert consultation requirements to health and disability claims and appeals.