[buck research]

fyi® for your information®

Volume 31 | Issue 46 | July 7, 2008

Conflict of Interest Must Be Considered a Factor in Claims Denial Cases

In Metropolitan Life Insurance v. Glenn, *the Supreme Court determined that a court must consider a conflict of interest as one of many factors in deciding claims for benefits cases.*

Background

In 1989, in *Firestone Tire and Rubber Co. v. Bruch*, the Supreme Court outlined the judicial standard of review in a claim for benefits case. In *Firestone*, the Court determined that where the plan gives discretion to a claims fiduciary, the court will review the claims administrator's determination under the abuse of discretion standard (which gives deference to the administrator's decision). If the plan does not provide this discretion, the court will review the determination under the de novo standard, under which the court makes the claims determination.

In *Firestone*, the Court remarked that where a claims fiduciary is acting under a conflict of interest (i.e., when the entity that decides the claim also pays the claim), that conflict must be weighed as a factor in determining whether there is an abuse of discretion. The *Firestone* case involved an employer with a self-funded plan that also decided claims under the plan. Since *Firestone*, courts have grappled with how to deal with a conflict of interest for both self-funded and insured plans.

The Metropolitan Litigation

In *Metropolitan Life Insurance v. Glenn*, Wanda Glenn was covered under her employer's long-term disability (LTD) plan. Metropolitan Life Insurance Company (MetLife) had full authority to decide all claims under the LTD plan, and it was responsible for making all payments. MetLife initially granted Ms. Glenn's claim for LTD benefits, and later denied extended benefits beyond 24 months, claiming she could perform sedentary work. Ms. Glenn sued, and the federal district court upheld MetLife's decision. On appeal, the U.S. Court of Appeals for the Sixth Circuit held in favor of Ms. Glenn, applying the deferential standard of review. The Sixth Circuit cited the fact that MetLife both decided and paid the claims as a factor in its determination and concluded that the district court did not give this conflict appropriate consideration. The Supreme Court agreed to review the case.

The Supreme Court Decision

The Supreme Court found that when an insurance company both decides and pays claims, there is an inherent conflict of interest for ERISA purposes. The court noted that the conflict could arise simply in the employer's

selection of the insurance company because the employer may be more interested in an insurance company with low rates rather than with one with accurate claims processing. Further, although the marketplace sets standards for services by insurers, ERISA imposes "higher-than-marketplace" quality standards on insurers who insure ERISA plans. An insurer must act solely in the interest of plan participants and beneficiaries, and any financial gain by the insurer in denying a claim would create a conflict.

> ***BUCK COMMENT.*** *It is unclear how lower courts will interpret the Supreme Court's language that an employer may have a conflict of interest when it purchases the lowest cost insurance. As a precaution, employers should have a process in place to show that the decision to select an insurer was not solely based on cost, but also on other factors such as quality claims administration and the fit of the product to the plan.*

The Court stated that a conflict should not change the standard of review from the deferential abuse of discretion standard to the de novo standard of review. Instead, courts should look at the conflict as one of the many factors involved in determining whether the claims administrator abused its discretion, and each case should be decided on the facts presented. For example, in close cases, the existence of a conflict could be the tie breaker where the administrator has a history of biased claims administration. The conflict might be less important ("perhaps to the vanishing point") where the administrator has taken active steps to reduce potential bias and promote accuracy (e.g., by walling off claims administrators from those interested in the company's financial concerns, or by imposing penalties for inaccurate decision-making).

> ***BUCK COMMENT.*** *Although* Metropolitan *involved an insured plan, the Court noted that employers who both fund and decide claims under a plan have an inherent conflict of interest. It is unclear how lower courts will interpret this language. Employers with self-funded employee benefits plans should review their claims procedures to make sure that any such conflict is minimized either by appointing as claims administrators individuals who have little or no financial stake in the company or appointing outside claims fiduciaries to handle claims administration.*

Conclusion

Although the *Metropolitan* case involved an insurer, the implications will reach to employers, self-funded plan claims procedures, and procedures for selecting insurers. Buck's consultants would be pleased to discuss *Metropolitan's* implications with you and help you review and revise your claims procedures and insurer selection process.