

Benefits Report

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***MetLife v. Glenn:* The Supreme Court Clarifies the Standard of Review for Decisions by Conflicted Plan Administrators**

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The U.S. Supreme Court's recent ruling in *Metropolitan Life Insurance v. Glenn* ("MetLife") attempted to answer two questions concerning ERISA benefits litigation, both of which have been a source of disagreement among the circuit courts of appeals:

- Does an entity that both funds benefits and decides claims operate under a conflict of interest?
- If such an entity does operate under a conflict,

how should such a conflict affect a court's review of a conflicted decisionmaker's determination?

The Court squarely answered "Yes" to the first question, and provided a framework — of sorts — in response to the second question. The Court's ruling, however, which was sharply criticized by four of the nine Justices, left open a number of issues for plan fiduciaries, their attorneys and the courts to grapple with in the future.

Background

Section 1132(a)(1)(B) of the Employee Retirement Income Security Act of 1974 ("ERISA") explains that participants in employee benefit plans have a right to bring a suit in federal court to recover benefit payments denied to them by their plan administrators and fiduciaries. ERISA remains silent, however, on the standard of "judicial review" of such claim denials — *i.e.*, the extent (if any) to which a court will defer to a plan administrator's reasonable decision, even if the court might disagree with that decision. Prior to the decision in *MetLife*, courts relied on the 1989 Supreme Court decision in *Firestone Tire and Rubber Company v. Bruch* (489 U.S. 101 (1989)) ("*Firestone*") for guidance in reviewing ERISA benefit denials. In *Firestone*, the Court set forth a set of principles describing the appropriate standard of judicial review:

- a court should be guided by trust law;

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- benefit determinations should be reviewed *de novo* (with no deference) unless the plan grants the claims fiduciary discretionary authority to determine eligibility, in which case such decisions would be reviewed under a deferential standard and would only be disturbed if the court finds that the fiduciary abused its discretion; and
- if the claims fiduciary with discretionary authority has a conflict of interest, that conflict will be weighed as a factor in determining whether or not there has been an abuse of discretion.

Following *Firestone*, many plan sponsors inserted language into their plan documents granting fiduciaries the necessary discretion in determining eligibility for benefits so that they would enjoy deferential review in the event of a lawsuit. Plaintiffs' attorneys have long argued, however, that a decision by a conflicted administrator — *i.e.*, one that both funds the benefit and decides the claims — should not be entitled to deference, but instead should be reviewed *de novo* by the court. The federal courts have been receptive to this argument in varying degrees, resulting in different views as to what exactly constitutes a conflict, and how a conflict should factor into the court's decision. Some courts applied a "sliding scale" approach, granting less deference to the decision as the severity of the conflict increased; in certain circumstances others required the claims fiduciary to demonstrate that its decision was *not* tainted by conflict. Still others did not even recognize that a conflict exists, explaining that ERISA expressly allows for the same entity to fund a plan and administer it. *MetLife* presented the Supreme Court with an opportunity to resolve these different approaches.

MetLife v. Glenn

Wanda Glenn was an employee of Sears Roebuck & Company diagnosed with dilated cardiomyopathy, a disorder which causes the heart to become weak, enlarged and inefficient. Following the onset of her complications, Wanda's doctor informed her that she could no longer work due to the physical and mental stress of her job. She presented appropriate evidence of her ailment to MetLife, the administrator

and insurer of the Sears Plan. MetLife then, acting in its discretionary authority, granted Glenn initial disability payments. By the plan terms, after 24 months Wanda was required to make a further showing that her disability prevented her from holding any job for which she was qualified in order to continue to receive benefits. Wanda's doctor submitted a report explaining that any employment would place too great a strain on her heart, and MetLife appointed its own specialist to review her medical file. Subsequently, MetLife denied Wanda's benefit claim, arguing that she could perform sedentary work. Wanda filed suit. The district court ruled in favor of MetLife, finding no abuse of discretion in denying the claim. The Sixth Circuit Court of Appeals overturned this decision after applying a sliding scale of deference, citing concerns over MetLife's conflict of interest in both funding the benefits and administering the plan.

Holding

The Supreme Court's majority opinion (authored by Justice Breyer) held that a plan administrator that both evaluates and pays benefits claims operates under a conflict of interest under *Firestone*, regardless of whether the administrator is an employer administering its own plan or an insurance company that has contracted with the employer to provide certain benefits. While the Court acknowledged that employer/administrators and insurer/administrators do not have identical incentives to deny possibly meritorious claims — the Court actually found that the *employer* administering its own plans was more obviously conflicted than the insurance company — it ultimately held that both operate under a conflict of interest.¹

Notwithstanding the existence of such a conflict, the Court held that, if the plan has the necessary language granting discretion, the administrator's decision must still be reviewed by a court under a deferential standard of review. The Court explained, however, that the conflict of interest should be weighed as one factor among many in determining whether or not the plan administrator abused its discretion.² The Court offered little practical guidance

¹ Justice Scalia, in a dissenting opinion joined by Justice Thomas, criticized the majority's opinion as it pertains to employers as unnecessary, since the case before the Court only involved an insurance company, not an employer that administered its own plan.

² The Court held that the Sixth Circuit sufficiently engaged in this analysis of all factors, and that its "serious concerns" about certain actions by MetLife, "together with some degree of conflicting interest on MetLife's part," supported the court's decision that MetLife had abused its discretion.

for judges who must “weigh” this factor in future cases, rejecting the idea that special procedural or burden-shifting devices were necessary, and stating simply that such a “facts and circumstances” review was “no stranger to the legal system.” The Court did identify some circumstances in which the conflict might be deemed more significant — *e.g.*, if the fiduciary has a history of biased claims decisions. In other cases, where the administrator had taken steps to ameliorate the conflict and eliminate possible bias (in the Court’s words, “by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decisionmaking irrespective of whom the inaccuracy benefits”), the weight of the conflict might be minimal, and perhaps even zero.

While the dissenting justices took issue with the majority’s “kitchen sink” approach that, in their view, violates trust law principles and eviscerates the deferential standard of review, the majority responded by echoing the Court’s conclusion in *Firestone* that the “want of certainty in judicial standards partly reflects the intractability of any formula to furnish definiteness of content for all the impalpable factors involved in judicial review.”

Impact of the Decision

The Court’s decision makes clear that the impact of a conflict of interest will vary greatly depending on the individual facts of each case. In reviewing a decision by a conflicted fiduciary, courts will have to weigh various factors, placing the conflict of interest in context in order to determine whether or not an abuse of discretion occurred in denying a claim. Plaintiffs’ lawyers may now argue that, in order to place the conflict “in context,” they need discovery about the fiduciary’s claims-handling history and practices, while fiduciaries may attempt to introduce evidence about the steps they took to ameliorate the conflict. A court’s consideration of these issues could possibly significantly increase the cost and time necessary to litigate an ERISA benefits claim (thereby undercutting one of ERISA’s primary goals, namely, speedy and efficient claims determination). While at least one district court has already rejected the notion that the *MetLife* decision opens the door to conflict-related discovery,³ the issue is sure to be litigated in other courts in the next few years.

The *MetLife* decision does offer conflicted fiducia-

ries some guidance on how to minimize the impact of the conflict of interest, and employers that administer their own plans should strongly consider following the Court’s suggestions. Such steps include:

- separating claims administrators from employees responsible for the company’s finances;
- eliminating *any* possible financial incentives to deny claims;
- shielding claims administrators from knowledge of the dollar amount of a particular benefit claim; and
- providing disincentives for inaccurate decision-making.

Implementing and abiding by clear claims-handling procedures would also help ameliorate an apparent conflict of interest. Further guidance for plan sponsors may well emerge in the next few years, as cases involving decisions by conflicted decision-makers make their way through the court system.



Department of Labor Issues Q&As on Form 5500 Schedule C Reporting for 2009

JENNIFER D. BROOKS

The Schedule C accompanying the Form 5500 for the 2009 plan year for large plans will be markedly different from the Schedule C previously required. On November 16, 2007, the Department of Labor (“DOL”) published a new Schedule C, effective for the 2009 plan year, which requires significantly more disclosure of service provider fees and compensation. On July 14, 2008, the DOL published additional guidance on the Schedule C requirements in the form of 40 Frequently Asked Questions (“FAQs”).

³ See *Dubois v. Unum Life Ins. Co. of America*, Civil No. 08-163-P-S, 2008 WL 2783283 (D. Me., July 14, 2008).

While the new Schedule C for the 2009 plan year is not generally due until 2010, plan sponsors and service providers should familiarize themselves with the new reporting requirements in order to be well prepared to comply by the required date.

The New Schedule C

The new Schedule C disclosure requirements are intended to increase transparency regarding fees and expenses paid by employee benefit plans, and to ensure that plan officials obtain the information they need to assess the reasonableness of compensation paid for services rendered to the plan.

Schedule C must be attached to the Form 5500 filed for a large pension or welfare benefit plan, or a direct filing entity (*e.g.*, common and collective trust), to report persons who rendered services to the plan and received, directly or indirectly, \$5,000 or more in reportable compensation in connection with the services provided to the plan, or in connection with their position with the plan. Direct compensation includes payments made directly by the plan for services rendered to the plan or because of a person's position with the plan. Examples of direct compensation include direct payments by the plan out of a plan account, charges to plan forfeiture accounts, and direct charges to plan participant individual accounts. Payments made by a plan sponsor that are not reimbursed by the plan are not subject to Schedule C reporting requirements. Compensation received by a service provider in connection with services provided to the plan or in connection with its position with the plan that is not received directly from the plan or plan sponsor is reportable as indirect compensation. Examples of reportable indirect compensation include sub-transfer agency fees, shareholder servicing fees, account maintenance fees, 12b-1 distribution fees, finder's fees, float revenue, brokerage commissions, and soft dollars. The level of disclosure required for a particular service provider depends on whether the service provider received only "eligible indirect compensation" or received compensation other than "eligible indirect compensation."

Eligible Indirect Compensation

Eligible indirect compensation includes fees or expense reimbursements charged to investment funds and reflected in the value of the investment or in the return on investment (*e.g.*, finders' fees, "soft dollar" revenue, float revenue, and/or brokerage

commissions). For such indirect compensation to be eligible indirect compensation, the plan sponsor must have received written disclosure of the following information:

- the existence of the indirect compensation
- the services provided for the indirect compensation or the purpose of the payment of the indirect compensation
- the amount (or estimate) of the compensation or a description of the formula used to calculate or determine the compensation
- the identity of the party or parties paying and receiving the compensation

If a service provider received only eligible indirect compensation, the plan sponsor must only identify the person who provided the necessary disclosure regarding the indirect compensation.

Indirect Compensation and Direct Compensation

For those persons who received direct compensation or indirect compensation that does not qualify as eligible indirect compensation, more detailed disclosure must be made. Such service providers must disclose the name, address and EIN of the service provider, the service code describing the services provided to the plan, the service provider's relationship to the plan, the amount of direct compensation paid by the plan and the amount of indirect compensation received (or alternatively, the formula used to determine the amount of indirect compensation).

FAQs Additional Guidance

The DOL received numerous questions regarding the new reporting requirements for Schedule C, and the FAQs were published to address many of those questions. Topics covered by the FAQs include the following:

- requirements for the limited reporting of eligible indirect compensation
- reporting compensation provided through a bundled arrangement or an "alliance" arrangement
- reporting of float income
- reporting requirements for a service provider who received both eligible indirect compensa-

tion and indirect compensation that does not constitute eligible indirect compensation

- use of a formula or an estimate to report indirect compensation
- methods for satisfying the disclosure requirement for eligible indirect compensation (*e.g.*, electronic disclosure)
- reporting of non-monetary compensation (*e.g.*, gifts, entertainment) received by service providers

Service Provider Failure or Refusal to Provide Information

Part II of Schedule C requires a plan sponsor to disclose identifying information for each service provider who failed or refused to provide the information necessary to complete the Schedule C. In

recognition of the difficulties many service providers face in order to supply their employee benefit plan clients with the information necessary to comply with the new reporting requirements of Schedule C, the DOL provides some transition relief. For the 2009 plan year, plan administrators will not be required to list a service provider on Part II if the plan administrator receives from the service provider a statement that the service provider made a good faith effort to make any necessary recordkeeping and information system changes in a timely fashion, and despite such efforts the service provider was unable to complete the changes in time to provide the information for the 2009 plan year.

The full text of the FAQs can be found at http://www.dol.gov/ebsa/faqs/faq_scheduleC.html.

Please contact us for more information on meeting these new requirements.

Trucker ♦ Huss Files Brief with the Supreme Court Regarding the Validity of Non-QDRO Waivers of Benefits

Trucker ♦ Huss filed an amicus curiae brief with the U.S. Supreme Court on July 15, in *Kennedy v. Plan Administrator for DuPont Savings and Investment Plan*, a case that may resolve the issue of whether a “waiver” of rights by one spouse in a divorce decree is binding on an ERISA plan when the spouse remains as the named beneficiary of a participant’s death benefits even after the divorce. The brief filed by Trucker ♦ Huss seeks affirmation of the decision of the 5th Circuit Court of Appeals in which that court held that, in the event of a divorce, a qualified domestic relations order (“QDRO”) is the only way to assign benefits under ERISA and that, absent a QDRO, an ex-wife’s purported waiver of her

rights to any of her former husband’s benefits did not invalidate the beneficiary designation that remained on file naming her as the beneficiary post-divorce. According to the brief, authored by Charles A. Storke and Robert F. Schwartz, benefit plans should not be required to look beyond their governing instruments and documents in administering benefit claims. Requiring them to do so would both impose significant costs on the plans (and therefore on the plan sponsors and/or participants), and decrease the certainty of participants, beneficiaries, and plan administrators as to the proper distribution of benefits under the plan. Oral arguments will be heard by the Supreme Court on October 7.

FIRM NEWS

Julie Burbank, Ben Spater and **Matt Gouaux** will be presenting a workshop for the San Francisco chapter of the National Institute of Pension Administrators (NIPA) on August 21 at the Embassy Suites Hotel in Walnut Creek. Julie and Matt will present the first session, on *Same-Sex Marriage — Impact on Employee Benefit Plans*. Ben and Matt will lead the second session, a *QDRO Workshop — Recent Developments and Question and Answer Session*.

On July 22, **Ben Spater** spoke to the Taxation and the Labor & Employment Sections of the Barristers Club of San Francisco. His topic was *ERISA 101 — The Law Governing Employee Benefit Plans*.

Clarissa Kang's May, 2008 article *The Department of Labor Amends and Supplements Qualified Default Investment Alternative Regulation* was reprinted this month in Kiplinger's online Business Resource Center.

Five of our attorneys, **Lee Trucker, Brad Huss, Barbara Creed, Charles Storke** and **Benjamin Spater**, have been selected as Northern California Super Lawyers for 2007 by Law & Politics Magazine. Attorneys selected for this honor represent the top 5% of attorneys in the area, nominated and elected by their peers. In addition, **Brad Huss** was also among the Top 100 Northern California Super Lawyers — one of those who received the highest evaluations in the balloting process.

The **Trucker + Huss Benefits Report** is published monthly to provide our clients and friends with information on recent legal developments and other current issues in employee benefits. Back issues of *Benefits Report* are posted on the Trucker + Huss web site (www.truckerhuss.com).
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In response to new IRS rules of practice, we inform you that any federal tax information contained in this writing cannot be used for the purpose of avoiding tax-related penalties or promoting, marketing or recommending to another party any tax-related matters in this *Benefits Report*.

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