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ERISA claims review: “Inapt, a historical mistake, or a mechanical extrapolation from different settings?”

Discretionary review of insured ERISA plans from the LMRA through MetLife v. Glenn

A great majority of the health, life and disability benefits provided by employers under the Employee Retirement Income Security Act of 1973, 29 U.S.C. sections 1001 et seq. (ERISA) are funded through the purchase of insurance. When an employee beneficiary sues over a denied claim, the courts are required to defer to the insurer’s decision, and to uphold it unless the employee can show the decision is “arbitrary and capricious” or an abuse of discretion.

There is nothing in the ERISA statute that mandates this result; this standard was imposed by judicial fiat. And, before one asks why the courts decided (or more specifically, why the U.S. Supreme Court decided) to defer to insurance claims handlers’ decisions, in fact they never really did.

Rather, a review of the case law shows that discretionary review of the decisions of insured ERISA plans is a historical accident. The standard was borrowed from trust law for Labor-Management Relations Act (LMRA) Section 302(c) trusts, borrowed again (without much analysis) for ERISA employer-funded plans, and borrowed yet again (with no analysis at all) for insured ERISA plans. In the recent *MetLife v. Glenn* decision, this standard was presumed to be correct, with no analysis whether this standard is legally required or appropriate for reviewing an insurance company’s denial of insurance benefits.

The ironic result is that the law now requires claims decisions by insurance companies – perhaps the least “trust like” entities on the planet – to be given the same deference given to the decision of impartial fiduciaries of a funded trust.

The fox is guarding the chicken coop

A registered nurse was fighting a 10-year battle with lupus. The drugs needed to combat the disease are toxic and her

physician, a world-renowned expert who had written the textbook on rheumatology, battled to maintain a balance between the impact of the disease on his patient, and the impact of the drugs.

The nurse’s condition eventually deteriorated, and her physician put her on disability. Her disability insurer initially paid benefits, and then started looking for grounds to deny her claim. It had the nurse examined by an independent physician, who agreed she was disabled. Then the insurer had the nurse placed under surveillance for eight days, which demonstrated that, for the most part, she sat in her home, acting just like one would expect a sick person to act.

Finally the insurer sent the nurse’s medical records to an allergist, a specialty with no connection to lupus. The allergist opined, without actually examining the nurse or even speaking to any of her physicians, that her condition was mild and she could go back to work. At that point the insurer ignored everything else, including the incensed letter from her treating physician and the contrary decision by Social Security, and cut her off.

Within six months the nurse disproved the allergist’s opinion that her lupus was mild in convincing fashion, by dying of it. But the insurer refused to re-examine its denial, refused to obtain new medical records, and when the late nurse’s counsel sent them in, failed to have them reviewed by a physician.

This was an actual case (*Wible v. Aetna* (C.D.Cal.,2005) 375 F.Supp.2d 956) and the above facts can be verified by looking at the detailed (and fairly outraged) opinion by the District Court. This is not an isolated example, as any attorney working in the employer-based life, health and disability field can cite example after example of overreaching by insurance companies.

So, how is it that an insurer believes it can act in such a cavalier fashion towards its insureds? Part of the answer, of course, is ERISA, which removed the fear of extra-contractual damages from the insurer’s decision-making process. Of equal importance, however, is the standard of review an ERISA plaintiff faces when he or she gets to court, which requires the trial court to defer to the insurer’s decision, unless it entirely lacks a reasonable basis.

This standard permits the insurer to make claim decisions safe in the knowledge that it will prevail in court unless the insured can show that the insurer had relied on “clearly erroneous findings of fact,” (*Estate of Shockley v. Alyeska Pipeline Serv. Co.* (9th Cir. 1997) 130 F.3d 403, 405) had acted in a manner that was “totally unreasonable,” (*Allen v. United Mine Workers of America 1979 Benefit Plan & Trust*, (7th Cir. 1984) 726 F.2d 352, 354) or made a decision that was “whimsical, random, or unreasoned.” (*Teskey v. M.P. Metal Products, Inc.* (7th Cir. 1986) 795 F.2d 30, 32). Stated another way, the insurer will prevail unless it “render[s] decisions without any explanation” or interprets the plan in a way that “clearly conflicts with the plain language of the plan.” (*Eley v. Boeing Co.* (9th Cir. 1991) 945 F.2d 276, 279).

This is especially remarkable, given that courts have long recognized that insureds require more protection than usual parties to a contract dispute, not less. People buy insurance as “protection against calamity” rather than for commercial reasons. (*Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 819, 145, [169 Cal.Rptr. 691, 695].) At the time of the claim, the insured is often sick, disabled or dead, and generally vulnerable. (*Fletcher v. Western National Life Ins. Co.* (1970) 10 Cal.App.3d 376, 404, [89

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Cal.Rptr. 78, 95].) Certainly, if a claim is unfairly denied, the insured can hardly “turn to the marketplace to find another insurance company willing to pay for the loss already incurred.” (*Foley v. Interactive Data Corp.* (1988) 47 Cal.3d 654, 692, [254 Cal.Rptr. 211, 234].)

Given this, one may well ask for the Congressional justification in giving an employee [who is] denied disability benefits less protection than a business complaining of a supplier’s failure to deliver the latest shipment of widgets. In fact, Congress did nothing of the kind. As the Supreme Court noted in *Firestone Tire and Rubber Co. v. Bruch* (1989) 489 U.S. 101, 108-109 [109 S.Ct. 948, 953], “ERISA does not set out the appropriate standard of review for actions under section 1132(a)(1)(B) challenging benefit eligibility determinations.”

Well then, if Congress did not require courts to defer to insurance company decisions, what were the courts thinking when they imposed this requirement on themselves? The irony is, of course, that the courts never really decided this either. This standard arose in the context of a different statutory structure dealing with express trusts, with disinterested trustees managing dedicated funds solely for the employees’ benefits.

It made sense in that context to borrow the “abuse of discretion” standard from the common law of trusts. Then, when ERISA was enacted and employee benefit plans run by insurance companies came within its sway, courts viewed the discretionary standard as well settled. A standard created for express trusts was applied – with no real analysis – to insurance company decisions about whether to pay benefits out of its own pockets.

In short, no one ever really decided that the courts should defer to insurance company decisions. Rather, discretionary judicial review of insurance company decisions is a historical mistake, based on unthinking application of standards created for different situations.

“But it seemed like such a good idea at the time”

Deferential review of decisions by employment-based plans got its start in

1947, when Congressional concern over the possible misuse of employer-contributed funds under labor union control led to the enactment of Section 302 of the LMRA. Section 302 prohibited payments by employers to employee representatives (i.e. unions), but section c excepted “a trust fund established by such representative, for the sole and exclusive benefit of the employees of such employer, and their families and dependents.” (LMRA § 302(c)(5)(B) (codified as 29 U.S.C. § 186(c)(5)(B)).) The trust was subject to the strict legal requirement that “employees and employers [be] equally represented in the administration of such fund.”

When the inevitable lawsuits arose challenging the decisions of the Section 302(c) trustees, the courts initially expressed some uncertainty over how to deal with them, or even if they were reviewable. Some courts decided that a denial of trust benefits should be treated as a simple breach of contract (*Hobbs v. Lewis* (D.D.C. 1958) 159 F.Supp. 282, 286), while others applied a discretionary standard. (*Ruth v. Lewis* (D.D.C. 1958) 166 F.Supp. 346, 349). In *Danti v. Lewis* (D.C. Cir. 1962) 312 F.2d 345, the D.C. Circuit held, with no analysis, that the proper standard was whether the “Trustees have acted arbitrarily, capriciously or in bad faith.” In spite of the lack of analytical support, this standard became generally accepted. (*E.g. Rehmar v. Smith* (9th Cir. 1976) 555 F.2d 1362, 1371).

Analytical support for this standard was supplied after the fact, from the “sole and exclusive benefit” language of Section 302(c). Courts found that “[t]he sole-and-exclusive-benefit standard limits the discretion of the trustees of a pension plan” (*Sailer v. Retirement Fund Trust of Plumbing, Heating and Piping Industry of Southern California* (9th Cir. 1979) 599 F.2d 913, 914). Stated another way, “arbitrary and capricious conduct is structurally deficient because it is deemed not to be for the sole and exclusive benefit of the employees.” (*Music v. Western Conference of Teamsters Pension Trust Fund* (9th Cir. 1983) 712 F.2d 413, 417).

Other courts justified deferential review on the grounds that it was the traditional standard used to review decisions

made by the fiduciary of a common law trust. “The institutional arrangements creating this Fund and specifying the purposes to which it is to be devoted are cast expressly in fiduciary form; and the Trustees, like all fiduciaries, are subject to judicial correction in a proper case upon a showing that they have acted arbitrarily or capriciously towards one of the persons to whom their trust obligations run.” (*Kosty v. Lewis* (D.C. Cir. 1963) 319 F.2d 744, 747). In other words, because Section 302(c) “explicitly casts authority to create such a fund in trust terms,” the traditional equitable standard of review of trustees actions was used to determine “whether their action was arbitrary or capricious.” (*Roark v. Lewis* (D.C. Cir. 1968) 401 F.2d 425, 426).

In *N.L.R.B. v. Amax Coal Co.* (1981) 453 U.S. 322, 329 [101 S.Ct. 2789], the Supreme Court affirmed that, given the explicit statement that assets in Section 302(c) funds would “be ‘held in trust,’ and be administered ‘for the sole and exclusive benefit of the employees... and their families and dependents...’” the Congress intended to incorporate the common law of trusts. “Where Congress uses terms that have accumulated settled meaning under either equity or the common law, a court must infer, unless the statute otherwise dictates, that Congress means to incorporate the established meaning of these terms.”

A plan is a plan is a plan: Application of the LMRA standard to ERISA

ERISA was enacted in 1974. Where Section 302(c) plans were limited to actual trusts involving money contributed by employers under joint employer/union control, ERISA’s scope included any plan that provided employee benefits, regardless of funding source or control. This included plans wholly controlled by the employer, and plans without independent funding sources. It even included plans that were wholly funded “through the purchase of insurance or otherwise.” (29 U.S.C. § 1002 (1)).

Had the first ERISA cases involved judicial review of benefit denials by insurance company representatives, courts

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might have hesitated to borrow the Section 302(c) trust-based standard of review. However, when the Federal courts were crafting a standard of review to decide the first ERISA cases, insured plans were absent from the field. During ERISA's early years, claims against insurers were rarely (if ever) brought under ERISA's statutory enforcement scheme.

This was due to the perceived impact of ERISA's "savings clause," which exempts state laws that regulate insurance from its broad preemption clause. (29 U.S.C. § 1144 (2)(A)). Courts initially believed that, while ERISA applied to plans funded through the purchase of insurance, a plan participant whose claim was denied was free to sue the insurer under state law. (See, for example, the reasoning of *Kanne v. Connecticut General Life Ins. Co.* (C. D. Cal. 1985) 607 F.Supp. 899).

In fact, it was not until 1987, 13 years after ERISA's enactment, that the seminal *Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41 [107 S.Ct. 1549] decision held that all state laws providing alternate enforcement actions were preempted, and that any lawsuit challenging the denial of ERISA benefits, even from an insured plan, had to be brought pursuant to ERISA.

In the meantime, of course, there had been a lot of litigation involving other, non-insured ERISA plans. These plans were generally funded by the employer or employees (or both) and, as such, they looked a lot like the Section 302(c) express trusts. As a result, the early ERISA cases, involving non-insured plans, adopted the Section 302(c) "abuse of discretion" standard.

For example, in the early ERISA case of *Bueneman v. Central States, Southeast and Southwest Areas Pension Fund* (8th Cir. 1978) 572 F.2d 1208, 1209, the court held that "judicial review of the trustees' action is limited to determining whether such action has been arbitrary or capricious, or an abuse of discretion." The court cited to a number of LMRA cases as authority for this proposition, and rejected the proposition that ERISA required a different standard.

This same standard was adopted in other circuits, all in the context of

employer or union-run plans. In *Smith v. CMTA-IAM Pension Trust* (9th Cir. 1981) 654 F.2d 650, 654, the Court referred to "[o]ur well-established rule [] that the decisions of those empowered with the administration of an employee pension trust shall be sustained unless arbitrary or capricious or contrary to law." The authority for the "well-established rule" were all cases decided under the LMRA. (*Gordon v. ILWU-PMA Ben. Funds* (9th Cir. 1980) 616 F.2d 433, 438-439). This same standard was adopted in other circuits, all in the context of employer or union-run plans. (E.g. *Riley v. MEBA Pension Trust* (2nd Cir. 1977) 570 F.2d 406, 410; *Bayles v. Central States, Southeast and Southwest Areas Pension Fund* (5th Cir. 1979) 602 F.2d 97, 99). Most of the time, little thought was given to the fact that, while some ERISA plans might be identical in form and structure to the Section 302(c) plans, other plans were significantly different.

"Second thoughts are ever wiser"

It was only after the abuse of discretion standard was enshrined for ERISA cases that some courts noticed that the broader definition of ERISA plans sometimes made that standard inappropriate. The Section 302(c) plans, by definition, had to be fully funded and under joint employer/employee control. However — even disregarding insurer funded plans, which weren't yet in play — ERISA allowed plans under the sole control of the employer. Worse, ERISA allowed plans that weren't fully funded, meaning the employer was deciding whether to pay some or all of the benefits out of its own pocket, rather than a funded trust.

Courts began questioning whether abuse of discretion was appropriate in these cases. For example, in *Van Boxel v. Journal Co. Employees' Pension Trust* (7th Cir. 1987) 836 F.2d 1048, 1049, Judge Posner acknowledged "the black-letter rule" that an ERISA pension trust's denial of benefits can be set aside "only if the decision is 'arbitrary and capricious.'" Judge Posner noted that this might have made sense in the context of Section 302(c) trusts, which were required by law to be under joint employer/employee control. Many of the ERISA trusts, how-

ever, were run entirely by the employer's agents:

This [section 302 "abuse of discretion"] standard was taken over for use in reviewing benefit denials under ERISA (which does not define the standard of judicial review of trustees' decisions on benefit claims), apparently without the courts' noticing that employers often held the whip hand in ERISA trusts as they did not with the joint employer-union trust funds authorized by Taft-Hartley. (*Van Boxel* at 1052).

Similarly, in *Varhola v. Doe* (6th Cir. 1987) 820 F.2d 809, 813, the Court recognized that, "[u]nlike ERISA," "Section 302 mandates that the pension fund be administered jointly by an equal number of employer- and employee-appointed trustees." The Court stated that, "[w]ere we writing on a clean slate, we might well be persuaded that stricter standard of review should apply to decisions by plan administrators of employer-controlled plans established under ERISA to deny benefits to particular claimants than to similar decisions by administrators of pension funds under section 302 of the LMRA." However, the Court recognized that the application of the "arbitrary and capricious standard to ERISA plans . . . is well-settled."

To account for these conflicted fiduciaries, courts began announcing a "flexible" or "elastic" treatment of the mandated "abuse of discretion" standard. For example, as noted by Judge Posner in *Van Boxel*, transferring the abuse of discretion standard from the LMRA to ERISA "may be inapt, a historical mistake, or a mechanical extrapolation from different settings, at once too lax and too stringent, but even if it is any or all of these things it is saved from doing serious harm by its vagueness and elasticity." Denied the right to deviate from this standard, the court decided it could mean different things in different contexts. "[T]he arbitrary and capricious standard may be a range, not a point" with a "sliding scale of judicial review."

Judge Posner was clear that he was endorsing a legal fiction, that the district

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courts, “while purporting to apply a uniform ‘arbitrary and capricious’ standard, in fact give less deference to a decision the more the trustees’ impartiality can fairly be questioned.” Other courts, usually with less candor about what they were doing, endorsed a flexible application of the required standard, depending on the level of conflict involved. (*E.g.*, *Jung v. FMC Corp.* (9th Cir. 1985) 755 F.2d 708, 711-712; *Struble v. New Jersey Brewery Employees’ Welfare Trust Fund* (3rd Cir. 1984) 732 F.2d 325, 333).

One court tried to take the high road. In *Bruch v. Firestone Tire and Rubber Co.* (3rd Cir. 1987) 828 F.2d 134 (*reversed*, *Firestone Tire & Rubber Co. v. Bruch* (1989) 489 U.S. 101 [109 S.Ct. 948]), the Plan was unfunded and completely controlled by the employer. As the Court noted, “every dollar provided in benefits is a dollar spent by defendant Firestone, the employer; and every dollar saved by the administrator on behalf of his employer is a dollar in Firestone’s pocket.” The Third Circuit held that “the principle articulated in section 187 [i.e. Section 302(c)] does not govern judicial review of such a trustee’s decisions.” It rejected discretionary review, in favor of treating the case like a simple breach of contract.

In *Firestone Tire and Rubber Co. v. Bruch*, *supra*, 489 U.S. 101 the Supreme Court disagreed. It reasoned that “ERISA abounds with the language and terminology of trust law,” suggesting Congressional intent that reference be made to trust law to determine the standard of review for judicial oversight of benefit decisions. This required, the Court held, discretionary review where the trustee was granted discretion in the plan document. And with a single line, the Court blessed the attempts by courts to apply a modified abuse of discretion standard where the fiduciary was operating under a conflict. “Of course, 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.’ Restatement (Second) of Trusts section 187, Comment d (1959).”

Thus, a trust-based standard was now locked into stone. By coincidence, this was right when denials from plans run and

funded by insurance companies, which are about the furthest things from trusts that the law can imagine, began to be litigated.

“What’s mine is mine; what’s yours is negotiable”

The *Bruch* Court’s application of a trust-based standard to an employer-managed unfunded plan – which looks very little like a trust – made sense from one perspective. The variations among employer-based plans makes drawing a bright line rule distinguishing them difficult. An employer-based plans can be an actual trust managed by a disinterested trustee, a trust run by a committee appointed by the employer, or a trust that is only partially funded, where the employer making benefit decisions has to pay part of the proceeds out of his own pocket. You can even have a completely unfunded plan, where the employer has the dual role of making benefit decisions and paying the benefits it decides are due. And even in a fully-funded plan, the employer knows it might be looking at greater future contributions tomorrow if too many claims are paid today.

Employer-funded plans therefore present a spectrum of conflict situations, with various levels of trustee disinterest. The *Bruch* Court declined to draw a line at some arbitrary point in the spectrum, mandating abuse of discretion review on one side of the line and *de novo* review on the other. Instead, it preferred a more flexible analysis that mirrored the complexity of the various types of employer/employer funded plans, or the level of fiduciary interest.

This spectrum does not exist for insured plans. The insurer is never disinterested because it is always paying benefits out of its own pocket. The employee never has any control, through representatives or otherwise, in making the benefit decision. An employee-based plan might bear more or less indicia of a common law trust, but an insured plan never bears any of them.

The distinction between insured plans and other plans is recognized in ERISA’s statutory structure. Congress

included plans funded through purchase of insurance within ERISA’s scope, but recognized these plans were not express trusts. When it required that “all assets of an employee benefit plan shall be held in trust by one or more trustees,” (29 U.S.C. § 1103(a)) it created exemptions for “any assets of a plan which consist of insurance contracts or policies” and “any assets of such an insurance company or any assets of a plan.” (29 U.S.C. § 1103(b)).

The distinction between employer plans and insured plans drawn in federal law is at the heart of the common law definition of a trust. The *sine qua non* of a trust is property divided between ownership and use. “A trust is any arrangement which exists whereby property is transferred with an intention that it be held and administered by the transferee (trustee) for the benefit of another.” (*Eggert v. Pacific States Savings & Loan Co.* (1943) 57 Cal.App.2d 239, 243 [136 P.2d 822]). A trust exists even where the document creating it doesn’t use that term, so long as it involves property held and managed by one party for the benefit of another. (*In re Shaw’s Estate*, (Cal.App. 1926) 198 Cal. 352, 359-360 [246 P.48].)

The Section 302(c) plans were trusts by necessity, as the statute required employer contributions that were managed by employer and employee representatives for the benefit of the employees. The plans created pursuant to ERISA that involved either employer or employee contributions were also trusts, with a trustee that sometimes had more of an interest in the trust assets. However, an insured plan involves an insurance company employee making the decision whether to pay insurance company funds. This isn’t a trust; the insurance company isn’t deciding how to allocate trust assets, rather it is deciding whether the contract it signed requires it to spend its own money.

Judicial deference to a trustee’s decisions makes sense, given the nature of a fully funded trust managed by an independent trustee. Courts recognize that the settlor who funded the trust should have his or her wishes respected as to the uses of the trust assets. “The settlor has

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placed this discretion in the trustee because he desires the trustee's honest judgment, and not that of the court." (*Sherman v. Sherman* (1966) 5 Ohio St.2d 27, 34 [213 N.E.2d 360].)

Most significantly, courts defer to a trustee's decisions because its position encourages honest decision making. The typical trustee isn't confronted with the choice of paying the trust assets to the beneficiary or keeping them itself. Rather, it is generally prohibited in using trust assets for his own interests, a prohibition that is maintained in ERISA. (29 U.S.C.A. § 1106). Instead, the trustee is generally deciding whether to pay trust assets to one beneficiary or maintain them for the use of future beneficiaries. "Common law trustees . . . are forbidden to engage in self-dealing; and with their impartiality thus assured it makes sense for a court to defer to their discretionary judgments." (*Van Boxel, supra*, 836 F.2d at 1051).

This is different with insured plans. The insurer is paying benefits out of its own assets. Every cent that the insurer doesn't pay out in benefits goes to the insurance company's bottom line. This financial interest doesn't necessarily make insurance company decisions wrong, or dishonest. It does, however, take away the guiding rationale for treating them with discretion.

"How did things ever get so far?"

When the first insured plans came up for decision, the courts could have hesitated to apply discretionary review, based on the differences between traditional employer based plans and insured plans. However by that point the standard was well-established, and neither the courts nor the litigants gave much thought to whether it should apply.

For example, in the Eleventh Circuit case of *Hoover v. Blue Cross and Blue Shield of Alabama* (11th Cir. 1988) 855 F.2d 1538, 1541, the Court applied the standard to an insured plan, holding it "well established that the actions of plan fiduciaries or administrators must be sustained as a matter of law unless a plaintiff can prove that such actions are arbitrary or capricious." It cited only to cases involving self-funded plans, with no analysis why

this trust-based rule should apply when the fiduciary was deciding whether to spend its own money. It didn't have to consider the issue, given that the plaintiff apparently stipulated to the standard of review. Other circuits followed suit, with a similar lack of analysis. (*E.g. Masella v. Blue Cross & Blue Shield of Connecticut, Inc.* (2nd Cir. 1991); 936 F.2d 98, 103 *Donatelli v. Home Ins. Co.* (8th Cir. 1993) 992 F.2d 763, 765; *Henkin v. Northrop Corp.* (9th Cir. 1990) 921 F.2d 864, 866).

In some cases, the application of the *Bruch* standard was painless because pre-*Bruch* there was no reason for insurance policies to contain discretionary clauses. So, while insurers went racing to amend their policies, courts were deciding that discretionary review would have applied, if only the insurance policy had the requisite language. (*Kunin v. Benefit Trust Life Ins. Co.* (9th Cir. 1990) 910 F.2d 534, 536-537).

At any rate, discretionary review became customary in insurance claims litigation, with no analysis as to whether it should apply given the vast differences between an insurer-funded and an employer-funded plan. I have been unable to find any court who sat back to consider why a trust-based standard was being applied to a plan with none of the indicia of a trust.

Ironically, the difference between an insured plan and a trust was noted by one of the circuits only when it was argued by the insurer. In *Wachtel v. Health Net* (3rd Cir. 2007) 482 F.3d 225 the insurer claimed the attorney-client privilege, and was faced with the rule that a trust fiduciary cannot assert the privilege against the trust's beneficiary. The insurer succeeded in sustaining the privilege by arguing successfully – and correctly – that it wasn't a trust and shouldn't be treated like one:

Health Net contends that the fiduciary exception recognized at common law does not apply to every entity which is designated a fiduciary under ERISA. Instead, it argues that a fiduciary such as HN-NJ – an insurance company which contracts with multiple employee benefit plans to provide health insurance to employee-beneficiaries, processes and pays claims using its own assets, obtains legal advice using its

own funds, and operates with an eye toward profits – falls outside the scope of the fiduciary exception.

No one should be holding their breath to see an insurer admit this with similar candor in the context of the standard of review.

If you don't know where you are going, you might wind up someplace else

This was the situation in January of 2008, when the Supreme Court granted certiorari in *MetLife v. Glenn* (128 S.Ct. 1117). *Glenn* was the first case taken by the Supreme Court that squarely addressed the proper standard of review in the context of an insured ERISA plan.

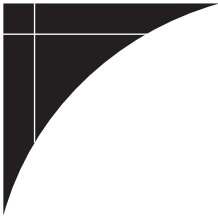
Maddeningly, all the merits briefs presumed that trust law was the starting point, as did all counsel at oral argument. Not surprisingly, the opinion of June 19, 2008, accepted this as a given:

In determining the appropriate standard of review, a court should be guided by principles of trust law; in doing so it should analogize a plan administrator to the trustee of a common law trust. (*Met Life v. Glenn*, ___, U.S. ___ (2008) (Slip Op. at 4) (attributions omitted).

Sour grapes aside, the *Glenn* decision did a few useful things at the margins. It held that the insurer's dual role as claims fiduciary and claim payer is enough, all by itself, to constitute a "conflict" that a court should take into consideration. (*Glenn*, Slip Op. at 5). Moreover, the Court declined to take the traditional path of using this "structural conflict" to impact the standard of review. Rather, the Court held that the standard should remain fixed at abuse of discretion, with evidence of the insurer's conflict and other indicia of bad faith used as "factors" to evaluate the propriety of the claims decision:

We believe that *Firestone* means what the word "factor" implies, namely, that when judges review the lawfulness of benefit denials, they will often take account of several different considerations of which a conflict of interest is one. (*Glenn*, Slip Op. at 10.)

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These are sensible and reasonable changes. However, given the frequency with which the Supreme Court takes an ERISA case, coupled with its reluctance to overturn what is now an established rule, it appears that litigants will be stuck with “abuse of discretion” review of denied claims for the foreseeable future.

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