I. Introduction
On June 19, 2008, the U.S. Supreme Court issued its opinion in the case of Metropolitan Life Insurance Co. et al v. Glenn (MetLife), affirming that the petitioner, Metropolitan Life Insurance Company (MetLife), had abused its discretion in denying the respondent, Wanda Glenn, long-term disability benefits. The ruling affirms the holding of the Sixth Circuit U.S. Court of Appeals, which found that MetLife "acted under a conflict of interest" and failed to provide a fair and balanced administrative process when it determined whether to approve Glenn's long-term disability benefits. Although the type of insurance benefit at issue in the MetLife case was long-term disability insurance, the Supreme Court's decision has broader implications for all employee benefit programs that the Employee Retirement Income Security Act of 1974 (ERISA) covers.

Broadly, ERISA sets standards for private sector "employee welfare benefit plans" and "employee pension benefit plans." Employee welfare benefit plans include insurance plans such as the long-term disability benefit at issue here and also health insurance plans provided by private employers. MetLife respondent, Glenn, sought judicial review of MetLife's denial of her long-term benefits as allowed under §1132 of ERISA. This civil remedy is available to any participant or beneficiary of an ERISA-covered benefit plan. Applying Firestone v. Bruch, the Court treated the benefit plan administrator as a trustee of a common-law trust so that a conflict of interest within that administrator "must be weighed as a factor in determining whether there is an abuse of discretion." Under this standard, the Court found that the Circuit Court properly found, weighed, and ruled that MetLife improperly acted upon its conflict of interest as a plan administrator and payor. The Court's ruling affirmed the decision against MetLife.

Six justices in MetLife agreed to rule against the petitioner insurance company, but only five justices agreed to the majority opinion in whole. Concurring only in part, Justices Roberts and Kennedy disagreed as to how much an insurer's conflict of interest should be weighed in an action arising under ERISA, and how that conflict of interest weight should be applied to the present case. At first blush, some reviewers have suggested that the Supreme Court has "put the thumb on the scale in the employees' favor." This paper summarizes and examines the Court's holding in MetLife and its application of Firestone, and examines if and to what extent this decision will shift policy under ERISA.

II. MetLife v. Glenn
The following section describes the facts behind MetLife v. Glenn and discusses the sequential court holdings up to and including the recent Supreme Court decision.

A. Facts
In 2000, the respondent in MetLife, Wanda Glenn, was an employee of Sears, Roebuck & Company when she was diagnosed with a disabling heart malady which rendered her unable to continue working. As the long-term disability insurance administrator and insurance payor for Sears, MetLife initially approved Glenn for 24 months of disability benefits. MetLife referred Glenn to a law firm so that she could apply for long-term disability benefits through the Federal Social Security program. MetLife initially approved Glenn for 24 months of disability benefits. MetLife further referred Glenn to a law firm so that she could apply for long-term disability benefits through the Federal Social Security program. Glenn was subsequently determined to qualify for the benefit under Social Security in 2002, retroactive to 2000. MetLife demanded and received over $13,000 out of the retroactive Social Security payments from Glenn, with the remainder of the payments going to the law firm that helped petition for the Social Security disability determination.

To continue receiving disability benefits from MetLife beyond 24 months, MetLife required Glenn to be evaluated by a much stricter standard. In denying extended benefits, MetLife appeared to have relied on a single evaluation from Glenn's physician, Dr. Patel, where he indicated that Glenn "was able to work in
a sedentary physical exertion level occupation.”

MetLife appeared to give no weight to other, more recent, more detailed and more declarative evaluations by Dr. Patel, namely that Glenn was unable to “handle any kind of stress well at her work.”

Glenn subsequently filed appeals with MetLife to reconsider the determination. MetLife eventually referred the case to an external medical evaluation consultant, Dr. Pujara. Upon later review, MetLife was found to have only forwarded Dr. Patel’s negative evaluations to Dr. Pujara, while excluding Dr. Patel’s other evaluations, which argued for Glenn’s continued disability status. Although Dr. Pujara’s report on Glenn’s status was arguably ambiguous, MetLife used the negative findings to deny once again Glenn’s further disability coverage. Glenn finally sued MetLife under the civil action provisions of ERISA. The District Court granted MetLife’s cross-motion for summary judgment based on the administrative record and Glenn subsequently appealed.

B. The Sixth Circuit

On appeal, the U.S. Sixth Circuit Court of Appeals reviewed the lower court’s decision de novo, applying the “arbitrary and capricious” standard [as did the lower court], because the plan at issue granted the plan administrator discretionary authority to interpret terms of the plan and to determine benefits. The Court of Appeals agreed with the District Court that MetLife had an inherent conflict of interest in being authorized both to “decide whether an employee is eligible for benefits and to pay those benefits.” and that this conflict was a relevant factor to be weighed in “determining whether abuse of discretion had taken place.” Nonetheless, the Court of Appeals found that the District Court had not appropriately given consideration to this inherent conflict of interest. Ultimately, the Sixth Circuit Court of Appeals reversed the District Court’s decision, finding that “MetLife acted under a conflict of interest,” and that MetLife failed to consider and reconcile fully the Social Security Administration’s determination and other physician’s evaluations, which found Glenn to be permanently disabled contrary to MetLife’s own final determination.

C. Certiorari

The U.S. Supreme Court granted certiorari to MetLife’s request that the Court determine “whether a plan administrator that both evaluates and pays claims operates under a conflict of interest in making discretionary benefit determinations.” Previously, Firestone only indicated that an employer, and not an insurance plan administrator, who evaluates and pays claims, operates under an inherent conflict of interest.

Further, the Supreme Court accepted the suggestion to determine “how any such conflict should be taken into account on judicial review of a discretionary benefit determination.”

D. Holding

In his majority opinion, Justice Breyer first affirmed the Sixth Circuit’s use of Firestone to apply trust law to the case at bar. This approach used a deferential standard of review where the plan administrator has “discretionary authority to determine eligibility for benefits.” Moving to the question of whether a conflict of interest exists for a plan administrator, as the Court found for an employer in Firestone, MetLife attempted to make an argument that an employer has a much more implicit conflict. MetLife further argued that finding such a conflict for plan administrators would run contrary to both “ERISA’s efforts to avoid complex review proceedings . . . [and] with Congress’s efforts not to deter employers from setting up benefit plans.”

Breyer conceded that a plan administrator, unlike an employer, is incentivized through the marketplace to provide accurate and less biased claims processing by the mere fact that a processor, with a reputation for inaccurate or biased claims, will lose business. Breyer argued that, although the market decreases the risk of inaccuracy and bias, the market does not fully eliminate that risk. First, according to Breyer, “the employer’s own conflict” may lead to its choice of the thrifty insurance plan over an accurate one. Further, Breyer found that “ERISA imposes higher-than-marketplace quality standards on insurers” which mandates a duty to plan beneficiaries and “full and fair review of claim denials.”

Moving to the matter of how to apply this conflict of interest in matters of benefit determination, the majority took a less structured approach. Breyer stated that new “special burden-of-proof rules . . . [and] special procedural or evidentiary rules” are unnecessary. Rather, the majority held that the Firestone model is a multi-factor weight test, whereby the courts will “take account of several different considerations of which conflict of interest is one.”

In such instances, any one factor will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor’s inherent or case-specific importance. The conflict of interest at issue here, for example, should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood.
that it affected the benefits decisions, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration.48

Applying this model to the lower circuit’s decision, the Supreme Court found that “the Court of Appeals gave the conflict weight to some degree,”49 but that other factors were given heavier weight to tip the scale in favor of the respondent, Glenn. These factors included the un-reconciled discrepancies between MetLife’s own benefit determination and the Social Security Administration’s determination, the failure to give all of Dr. Patel’s evaluations to the independent reviewer, Dr. Pujara, and the failure to factor properly all of Dr. Patel’s and Dr. Pujara’s evaluations into MetLife’s final determination.50

Closing the majority’s affirmation against MetLife, Breyer used the case of Universal Camera Corp. v. NLRB51 to support the majority’s decision and to avoid dictating an exacting formula with which to factor in a conflict of interest: “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.”52

E. Concurrences in Part

Concurring Justices Roberts and Kennedy, however, split from the five justice majority on the majority’s method of factoring in an insurer’s conflict of interest and the application to the case at bar. Although Chief Justice Roberts agreed with the majority’s finding that an insurer, like an employer, who administers and funds a plan, has a conflict of interest,53 he expressed the opinion that the majority went too far with a “kitchen-sink approach.”54 Rather, Roberts would prefer that consideration of a conflict of interest in judicial review were limited to those cases in which the evidence potentially implied “that the benefits denial was motivated or affected by the administrator’s conflict.”55 As a matter of policy, Roberts argued, “certainty and predictability” are critical guarantees to employers providing benefits pursuant to ERISA.56 Despite this disagreement in judicial model construction, Roberts ultimately agreed with the resulting judgment against MetLife, finding that the inconsistencies in MetLife’s determinations provided adequate deciding weight “wholly apart from MetLife’s conflict of interest.”57

Conversely, Justice Kennedy agreed with the framework constructed by the majority, but disagreed with the ultimate affirmation of the Sixth Circuit Court of Appeals judgment against MetLife.58 According to Kennedy, the majority’s model provided protection for “the interests of plan beneficiaries without undermining the ability of insurance companies to act . . . as plan administrators and [payors].”59 The protection for insurance companies, Kennedy elucidated, arose from the majority’s “recognition that a structural conflict should prove less important” where there is adequate evidence that the insurer has insulated the benefit determinations from this conflict.60 By simply affirming the Sixth Circuit decision, Kennedy asserted that MetLife was deprived of its fair day in court with the newly minted standard of review.61 According to Kennedy, the case should be remanded, allowing MetLife to provide evidence that Glenn’s benefit denial was adequately insulated from MetLife’s conflict of interest. This decision then would allow for a rebalancing of the multi-factor test to determine if the other discrepancies were egregious enough to condemn MetLife without the conflict of interest.62

F. The Dissent

Justice Scalia’s dissenting opinion, joined by Justice Thomas, combined the spirits of the disagreements voiced by Justices Roberts and Kennedy. Scalia wrote that, although he agreed that MetLife had a conflict of interest vis-à-vis its dual role as benefits determiner and payor,63 if a court were to apply the majority’s multi-factor test, the factors would “all be chucked into a brown paper bag and shaken up to determine the answer.”64 Like Chief Justice Roberts, Scalia would only allow inclusion of a conflict of interest as a deciding factor if and when evidence suggests that “the conflict actually and improperly motivates the decision.”65 Scalia based his perspective on a constructionist adoption of the Second Restatement of Trusts, whereby a court would substitute a de novo judgment where a plan administrator “had no discretion [or] had discretion and abused it.”66 Similar to Kennedy, Scalia would remand the case at bar for review of Glenn’s benefit denial. Unlike Kennedy, Scalia would completely exclude reassessment or consideration of any such conflict of interest held by MetLife.67
G. Summary of MetLife

Although the nine justices disagreed on the circumstances in which a conflict of interest should be factored into the judicial review of an employee benefits determination, they all agreed that a conflict of interest is present in some form for those third-party insurers that both determine a participant’s eligibility for a benefit and directly pay for that benefit. This homogeneity should provide ERISA payors cautionary notice that any inappropriate application of their inherent conflict of interest will be viewed with serious aversion by the courts. The result, in itself, achieves the majority’s goal of affirming a “higher-than-marketplace quality standard” on those insurers that provide ERISA benefits.

III. Firestone v. Bruch

Given the weight of precedent accorded to the 1989 Firestone decision in MetLife, this article briefly turns to review Firestone and its application to ERISA.

A. Facts

In 1980, the petitioner employer, Firestone and Rubber Co. (Firestone), provided to its employees a number of ERISA-governed employee pension and welfare benefit plans, which Firestone self-administered and paid. That same year, Firestone sold a number of its plants, which employed over 500 workers, to another corporation. After the sale, Firestone essentially separated itself as an employer from the workers in the plants that had been sold. As a result, a number of the workers filed for severance benefits under the termination pay plan — one of the ERISA-governed benefit plans. Several other respondents petitioned Firestone for disclosure of benefit provisions as allowed by ERISA. Firestone first denied the workers’ request for severance under the termination pay plan arguing that the plan’s trigger for severance benefits of a “reduction in work force” was not met by the sale of the plants. In addition, Firestone denied the request for disclosure citing that the employees “were no longer participants” and therefore not entitled to disclosure under ERISA. The employees subsequently filed a civil action as allowed under §1132(a)(1) of ERISA.

B. Lower Court Decisions

Similar to the procedural history of MetLife, the District Court granted significant deference to the determinations by Firestone and found in their favor. First, the District Court found that Firestone’s “decision not to pay severance benefits to respondents under the termination pay plan was not arbitrary or capricious.” Second, the District Court determined that the respondents’ requests for disclosure were not made while they were actual participants of the benefit plans but, rather, after they no longer participated.

On appeal, the Third Circuit was less willing to grant such great deference to Firestone’s determinations, overturning the District Court’s holding for the petitioner on these two counts. The Court of Appeals held that where an employer is itself the fiduciary and administrator of an unfunded plan, its decision to deny benefits should be subject to de novo judicial review. It reasoned that in such situations deference is unwarranted given the lack of assurance of impartiality on the part of the employer.

The U.S. Supreme Court granted certiorari to untangle discrepancies in the standard of review for actions brought under ERISA.

C. Holding in Firestone

Justice O’Connor, speaking for the Court, rejected Firestone’s multiple arguments that an arbitrary and capricious standard of review would be appropriate for civil actions brought under ERISA. Firestone argued that, since Congress intended to “incorporate much of [L]abor Management Relations Act (LMRA)] law into ERISA . . . the LMRA arbitrary and capricious standard should [also] apply to ERISA actions.” Nonetheless, the Court found that the arbitrary and capricious standard, which is accorded actions under LMRA, does not automatically translate to ERISA actions. This is largely because ERISA, unlike LMRA, “explicitly authorizes suits against . . . plan administrators [as a] remedy.”

O’Connor subsequently moved to affirm the application of trust law principles to ERISA, applying the precedent set in Central States, Southeast and Southwest Areas Pension Fund v. Central Transport (Central States). Applying these trust law principles, the Court set forward that ERISA plan administrators, like trustees, will be subject to “a deferential standard of review . . . when . . . exercise[ing] discretionary powers.” Further, courts will apply the de novo standard of review in those cases involving the interpretation of a plan’s terms.

As later seen in MetLife, Firestone also raises the policy concern that these heightened standards of review “would contravene the spirit of ERISA because it would impose much higher administrative and litigation costs and . . . discourage [the creation of] benefit plans.” Nonetheless, the narrower standard of de novo is unlikely to create new and litigation under ERISA.
D. Summary of MetLife and Firestone

The holdings in MetLife and Firestone are largely consistent with one another. Courts have indicated that a plan administrator executes a fiduciary act in making a benefit determination analogous with fiduciary acts by trustees in the common law. In its establishment of de novo and a deferential standard of review, the Supreme Court further sets the tone that the judiciary will not automatically show discretion to employers and insurers that administer and fund employee benefit plans.

IV. ERISA in the Broader Context

**MetLife** and **Firestone** both involve employee benefit plan-types which fall under the scope of ERISA. ERISA, however, has even broader applicability and has come under increased scrutiny as public dissatisfaction with health insurance in the United States has grown. This section will discuss the origins of ERISA and its present-day scrutiny.

A. Original Concerns and Design

Congress passed ERISA out of a concern over the adequate funding and preservation of employer-sponsored benefits for employees, which had been growing over the previous twenty years. This concern developed after the epic collapses of some benefit plans, such as the collapse of automobile manufacturer Studebaker in 1963. During a period of financial duress, Studebaker management and the United Auto Workers Union (UAW) thinned out the funding timeline of the pension plan while maintaining wages. The deal only delayed the company’s inevitable collapse by a couple of years.

Employees of the company, including those who had forty years or more of tenure, lost approximately $15 million in pension benefits.

With public pressure pushing for government protections from such catastrophes, Congress finally moved to pass ERISA. Like most bills that pass Congress, however, ERISA was not without its compromises. Although the legislation provides certain protections and guarantees to workers as beneficiaries of employer-sponsored benefit programs, the law also gave employers protections of their own. Employers who provided ERISA benefit programs were guaranteed federal protection from varied and overly burdensome state laws from the fifty states. Thus, employers were given “the ability to provide a uniform set of benefits to employees across state lines.”

This federal preemption from state law focused on protecting multi-state employers from state legislators more easily influenced by state lobbyists, and more willing to make “off-budget regulatory transfers” leading to an increased cost of health care insurance nationally.

B. Developing Concerns in Health Care

Although the intent behind ERISA was noble enough, frustration with the federal preemption of state health insurance reform has grown over the past fifteen to twenty years. In the early to mid-1990s, state governors were mounting their own federal policy push alongside President Bill Clinton’s 1993 national health care reform proposal. State governors became involved mostly out of concern that Clinton’s proposal would fail.

Even then, governors were frustrated by ERISA and other federal laws which prohibited states from mandating any level of health benefits from ERISA-covered employers while requiring an increase in payments to hospitals and nursing homes serving low-income populations.

The state clamor for reform has grown to a fever-pitch over the past few years. Maryland was the first state to act, passing the Fair Share Health Care Fund Act (Maryland Health Care Act) in January 2006. The Maryland Health Care Act sought to make Wal-Mart a “poster-child” for the problems with ERISA protections.

States complained that, although Wal-Mart provided a health package that was protected from state interference, the health package remained out of
reach for a significant plurality of Wal-Mart’s lowest paid workers, leaving state budgets and state-funded health care programs (e.g., Medicaid) to cover the gaps in coverage. In fact, Wal-Mart would have been the only employer affected by the Maryland law, which would have required the company to contribute “8 percent to 11 percent of their payroll to health insurance or contribute a fee to a state fund.” The Federal District Court intervened and found that ERISA preempted the Maryland law, thus making it invalid. Despite the contravening federal ruling, Maryland’s legislative efforts and those of other states embody the notion that, over time, ERISA has given greater leverage to “large employers at the expense of individuals and small businesses, who lacked capital to self-insure or cover their own health care costs.”

Even with the threat of ERISA preemption litigation, another state, Massachusetts, has begun implementing a comprehensive health care reform package that was signed into law in April 2006. The Massachusetts law creates a mandate that individuals purchase health care insurance, while assessing per-worker tax on employers with ten or more employees who do not already provide insurance to their employees. The plan also proposes to extend subsidies to low-income families and expand Medicaid coverage in the state. Although Maryland’s attempt at reform was quickly struck down under ERISA, Massachusetts’s reform proposal remained unchallenged. Two key differences protecting Massachusetts from preemption challenges are that, first, the program only assesses those employers who do not already provide a health care benefit (i.e., an ERISA protected benefit). Conversely, the Maryland plan unabashedly targeted Wal-Mart, a company already providing a health benefit, albeit meager. Second, the mandates on employers are loosely defined as requiring “fair share contributions to health care” and “cafeteria plan[s] that permit[] workers to purchase health care with pre-tax dollars.” These two differences represent key negotiations by Massachusetts legislators, who recognized the goals and preemption authority of ERISA and worked toward a solution that fills in the gaps left by ERISA.

V. Conclusion
A discussion tying together a seemingly narrow Supreme Court ruling on the standard for judicial review of an employee’s denial of long-term disability benefits and sweeping state-led health care reform may be seen as loosely drawn together. Case studies — ranging from disability benefit challenges in MetLife, to pension benefit challenges in Firestone, to federal preemption of Maryland’s reform, to whether compromises in Massachusetts will protect their attempt at universal health care coverage — all fall under the very large federal umbrella of ERISA.

In many ways, that the Massachusetts reform package began implementation in 2007 without a legal challenge under ERISA is impressive in and of itself. As shown historically by Central States and Firestone, large employers aggressively defend their autonomous discretion to create and maintain employee benefit programs that cross state lines. In fact, as recently as November 2007, large employers like AT&T and Xerox teamed together in a lobbying coalition, the National Coalition on Benefits, to preserve their nationwide autonomy. With the formation of the coalition, a General Motors (GM) government affairs executive cited the motivation to join as a desire to keep benefits at “the same level” for all GM employees. The lack of challenge to Massachusetts’s reform package and the Supreme Court’s conflict of interest bar-setting in MetLife may be indicators of the shifting policy environment alluded to by American Enterprise Institute Fellow Scott Gottlieb, recognizing the oversized leverage enjoyed to date by large employers under ERISA. Indeed, in his MetLife dissent, Justice Scalia expressed the view that the majority had gone too far in its wholesale declaration that both third-party insurers and employers operated under an inherent conflict of interest which must be weighed in review of benefit denials. Properly interpreted, rather than simply affirming the Court of Appeals’ ruling against MetLife, or even denying certiorari, the majority instead chose to make a seemingly small policy declaration that these plans and employers should be on notice of improper administration of their employee benefits. Further, given the Court’s ease in applying these standards across different forms of ERISA-covered plans, all administrators of ERISA-covered plans, including health care management organizations and pharmacy benefit managers, should consider taking a cautionary approach rather than an overly cavalier attitude towards benefits’ denial and cost control.

Taking a view across the spectrum of ERISA protections for employers and employees, there have been growing concerns over gaps and cracks in benefits coverage — from health care in Massachusetts to disability benefits provided to Sears employees like respondent Wanda Glenn. Thus far, analysts believe that MetLife’s holding will only “make a difference in close cases.” That said, large employers and their insurers should be watchful of large-scale legislative attempts to reform and even overhaul ERISA and health care at large.

1 MetLife is a long-term disability benefits administrator and insurer.
6 MetLife, supra note 2 at 2347.
8 MetLife, supra note 2 at 2347.
9 Id. at 2348 (quoting Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989)) (internal quotes omitted).
10 Id. at 2352.
11 Id.
12 Id. at 2345.
13 Id. at 2352.
14 MetLife, supra note 2 at 2356.
16 MetLife, supra note 2 at 2346.
17 Id.
18 Id.
19 Id. at 2346-47.
20 Glenn, supra note 3, at 663.
21 MetLife, supra note 2, at 2347.
22 Id.
23 Glenn, supra note 3, at 664 (internal quotes omitted).
24 Id.
25 Id. at 670.
26 Id. at 665.
27 Id. at 670.
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28 Id. at 665.
29 Glenn, supra note 3, at 665.
30 Id.
31 Id. at 665-66.
32 Id. at 666.
33 Id.
34 Id. at 674.
35 Glenn, supra note 3, at 674; see also MetLife, supra note 2, at 2347.
36 MetLife, supra note 2, at 2347.
37 See id. at 2348.
38 Id. at 2347 (quoting Brief for United States as Amicus Curiae on Pet. For Cert. 22) (internal quotes omitted).
39 Id. at 2347-48.
40 Id. at 2348-49.
41 Id. at 2349.
42 MetLife, supra note 2, at 2349.
43 Id. at 2349-50.
44 Id.
45 Id. at 2350 (analyzing 29 U.S.C. §1104(a)(1) (2006) and quoting Firestone, supra note 9, at 113) (internal quotes omitted).
46 Id. at 2351.
47 Id.
48 MetLife, supra note 2, at 2351.
49 Id.
50 Id. at 2352.
52 MetLife, supra note 2, at 2352 (quoting Univ. Camera Corp. v. NLRB, 340 U.S. 474, 477 (1951)) (internal quotes omitted).
53 Id.
54 Id. at 2354.
55 Id. at 2353.
56 Id. at 2354.
57 Id. at 2355.
58 MetLife, supra note 2, at 2355-56.
59 Id. at 2356.
60 Id.
61 Id. at 2356.
62 Id.
63 Id. at 2356-57.
64 See MetLife, supra note 2, at 2358.
65 Id. at 2357 (emphasis omitted).
66 Id. at 2359.
67 Id. at 2361.
68 See id. at 2348 (finding that MetLife has a conflict of interest); id. at 2352 (Roberts, J. concurring) (finding dual role creates conflict of interest); id. at 2355-56 (Kennedy, J. concurring) (agreeing with majority’s framework for establishing and reviewing an insurer’s conflict of interest); id. at 2356-57 (Scalia, J. dissenting) (agreeing that MetLife has a conflict of interest through its dual roles). But cf. id. at 2357 (Scalia, J. dissenting) (disagreeing with the majority’s assertion “that an employer who administers its own ERISA-governed plan ‘clearly or has a conflict of interest”).
69 Id. at 2350.
70 Firestone, supra note 9, at 105.
71 Id.
72 Id.
73 Id. at 106.
74 Id.
75 Id. at 106.
76 Firestone, supra note 9, at 106.
77 Id. at 106-7.
78 Id.
79 Id. at 107.
80 Id.
81 Id. at 107-8.
82 Firestone, supra note 9, at 109.
83 Id. at 110.
84 Id. at 111. See also Cent. States, Se., & Sw. Areas Pension Fund v. Cent. Transp., 472 U.S. 559, 570 (1985) (“Congress invoked the common law of trusts”); id. at 570 n.10 (cites ERISA statute and Congressional legislation which used explicit trust language).
85 Firestone, supra note 9, at 111.
86 Id. at 112.
87 Id. at 114.
88 Id. at 115.
89 MetLife, supra note 2, at 2347; Firestone, supra note 9, at 110.
90 MetLife, supra note 2, at 2348.
92 Id.
93 Id.
94 Id.
99 Id.
100 Hakim, supra note 96.
102 Id.
104 Barbaro, supra note 102.
105 Abelson, supra note 104.
109 Id.
110 Id.
111 Abelson, supra note 104.
112 See Mass Leaders, supra note 109.
113 See Abelson, supra note 104.
116 Id. (quoting Annette Guarrisco, executive director of federal affairs for General Motors, “We want to have the same level of coverage for everybody”).
117 Gottlieb, supra note 107.
118 MetLife, supra note 2, at 2356-57.
119 Walsh, supra note 15 (quoting Lonie A. Hassel, a partner at Groom Law Group).