

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF CALIFORNIA

DAVID WALKER,

No. C 07-03772 WHA

Plaintiff,

v.

**ORDER DENYING  
CROSS-MOTIONS FOR  
SUMMARY JUDGMENT  
AND PROPOUNDING  
INTERROGATORY TO  
DEFENDANT METLIFE**

METROPOLITAN LIFE INSURANCE  
COMPANY, KAISER PERMANENTE  
FLEXIBLE BENEFITS PLAN,  
and DOES 1 through 10, inclusive,

Defendants.

**INTRODUCTION**

In this disability-benefits action under the Employee Retirement Income Security Act, plaintiff David Walker sued defendants Metropolitan Life Insurance Company and the Kaiser Permanente Flexible Benefits Plan for denying his claim for long-term disability benefits. The proper standard of review for MetLife’s claim determination is abuse of discretion. A necessary factor in the abuse of discretion analysis is MetLife’s undisputed structural conflict of interest as both claim administrator and payor. MetLife’s conflict is compounded by its reliance on allegedly biased physician reviewers. Critical gaps in the administrative record render it insufficient to properly vet the influence of MetLife’s conflict, as compounded by its reliance on the physician reviewers, on its exercise of discretion. Therefore, the parties’ cross-motions for summary judgment are **DENIED** and MetLife is hereby ordered to produce,

1 **WITHIN THIRTY DAYS**, the information described in the court-ordered interrogatory propounded  
2 below.

3 **STATEMENT**

4 Mr. Walker worked as a local area network administrator for Kaiser Foundation  
5 Hospitals from March 1998 until August 20, 2005, at which point he took a medical leave of  
6 absence and has not since returned to work. Mr. Walker's job, according to the description  
7 provided by Kaiser, required him to provide technical support and training and involved sitting,  
8 walking, bending, and occasional lifting of up to fifty pounds. According to Mr. Walker, sitting  
9 at a computer and typing is only a small part of what he did. He maintains he also had to lift  
10 and carry computers, replace monitors, and "crawl around the floor connecting wiring for  
11 computers and climbing up in ceilings pulling wires" (AR 180).

12 As a Kaiser employee, Mr. Walker participated in the Kaiser Permanente Flexible  
13 Benefits Plan, a welfare-benefit program governed by ERISA which designated MetLife as the  
14 insurer of benefits and the claim fiduciary. In January 2006, Mr. Walker filed a claim for  
15 long-term disability benefits with MetLife on the ground that he was totally disabled from  
16 working in his occupation due to cardiac and blood pressure problems which left him with  
17 shortness of breath, chest pain, and insufficient stamina. Under the terms of the plan,  
18 participants of at least 61 years of age, like Mr. Walker, were entitled to a maximum benefit  
19 duration of 48 months, provided they were found totally disabled. The plan stated, in pertinent  
20 part (emphasis added):

21 You are considered totally disabled if:

- 22 • During your elimination period (see below) and the next  
23 24-month period, you are unable to earn more than 80% of  
24 your pre-disability earnings at your own occupation for any  
25 employer in your local economy, or;  
26 • After the first 24 months, you are unable to earn more than  
27 80% of your indexed pre-disability earnings from any  
28 employer in your local economy at any gainful occupation  
for which you are reasonably qualified, taking into account  
your education, training, experience and pre-disability  
earnings.

Your loss of earnings must be a direct result of your sickness,  
pregnancy or accidental injury. Economic factors such as, but not

1 limited to, recession, job obsolescence, pay cuts and job-sharing  
2 will not be considered in determining whether you meet the loss of  
earnings test.

3 *Your elimination period is the six-month period of time during*  
4 *which no LTD [long-term disability] benefits are payable,*  
5 *beginning on the day you became disabled. You must be under*  
6 *continuous care of a doctor during your elimination period.*

7 (*id.* at 108). Given the plan’s six-month elimination period, in order to award benefits to  
8 Mr. Walker MetLife would have had to find him totally disabled from his last day of work on  
9 August 20, 2005 through February 10, 2006.

10 The plan also required that participants seeking disability apply for disability benefits  
11 with the Social Security Administration. Mr. Walker did so and in September 2006 the Social  
12 Security Administration awarded him disability benefits of approximately \$1,440.50 per month,  
13 including a back payment award of \$8,934 for the period beginning February 2006 through  
14 August 2006 (*id.* at 258–260). The record in this case includes only the award itself, without any  
15 accompanying documents indicating the basis upon which the award was made. There is no  
16 evidence that MetLife considered the Social Security award in its decision to deny Mr. Walker’s  
17 claim, or that it sought to obtain information regarding the basis of the Social Security  
18 determination.

19 The medical records on file in this case show Mr. Walker suffered from conditions  
20 including diabetes, hypertension, dyslipidemia, glaucoma, coronary vascular disease, organic  
21 heart disease, high blood pressure, macular degeneration of his left eye, and blindness since birth  
22 in his right eye. An “Attending Physician’s Statement” completed at the request of MetLife by  
23 Mr. Walker’s primary care physician at Kaiser, Dr. George Chuang, M.D., listed Mr. Walker’s  
24 functional capacity as Class 3 (Marked Limitation), and advised that Mr. Walker not return to  
25 work until July 2006. Dr. Kathleen Kelley, however, a physician consultant retained by MetLife  
26 to review Mr. Walker’s file, concluded there did not appear to be documentation of significant  
27 functional impairment past October 2005. Based on this lack of documentation, Dr. Kelley  
28 opined that Mr. Walker was “able to function in his own occupation beyond that date” (*id.* at  
531).

1 Dr. Kelley recommended that her report be sent to Dr. Chuang for a response. She asked  
2 that Dr. Chuang comment on Mr. Walker's shortness of breath, vision, fatigue, cardimyopathy,  
3 and pulmonary diagnoses. In April 2006, MetLife sent a copy of Dr. Kelley's report and  
4 questions to Dr. Chuang. The following month Dr. Chuang responded. The entirety of his  
5 response consisted of a brief handwritten note stating, "Noted. I agree with the plan for  
6 long-term disability" (*id.* at 494). Mr. Walker argues the note indicates "Dr. Chuang did not  
7 read the materials sent to him but rather confirmed his 'plan' for long term disability for  
8 Mr. Walker. As nothing was sent to Dr. Chuang about MetLife's 'plan' for long term disability,  
9 it would seem reasonable to understand Dr. Chuang as referring to his previous plan for Mr.  
10 Walker to stay off work" (Plaintiff's Br. 7).

11 Maintaining that Dr. Chaung had agreed with Dr. Kelley's assessment, MetLife found  
12 that Mr. Walker was unable to perform his occupation through October 2005 but was able to do  
13 so thereafter. This finding rendered Mr. Walker ineligible for benefits, as he was determined to  
14 not be continuously disabled throughout the six-month elimination period. MetLife wrote to  
15 Mr. Walker stating his claim had been denied.

16 In August 2006, Mr. Walker appealed. His counsel requested a copy of his file and  
17 asked that the appeal not be decided until they could review the entire file and submit additional  
18 evidence. In February 2007, Mr. Walker submitted a 187-page formal appeal. Included therein  
19 was a letter from Dr. Jason Jones who had performed laser eye surgery on Mr. Walker, over  
20 100 pages regarding medication side effects, and the results of a stress test showing Mr.  
21 Walker's susceptibility to shortness of breath and chest tightness. The appeal letter asserted Mr.  
22 Walker remained disabled after October 2005 due to his medical conditions and medication side  
23 effects. Mr. Walker stated he continued to suffer from congestive heart failure, diabetes  
24 mellitus, peripheral neuropathy, nephropathy, hypertension, chronic renal failure, coronary  
25 vascular disease, fatigue, dizziness, lightheadedness, blurred vision, nervousness, chest pain,  
26 confusion, and headaches. He stated Dr. Chuang had opined that he remained "very limited" and  
27 unable to "sustain an 8 hour workday in any career given his symptoms" (AR 262).  
28

1 MetLife referred Mr. Walker's file to the independent medical referral bureau, National  
2 Medical Review ("NMR"), requesting physician reviews and answers to specific questions from  
3 members of NMR's physician panel with appropriate areas of specialization (*id.* at 252). NMR  
4 referred Mr. Walker's file to internist and cardiologist, Dr. Michael J. Rosenberg, and to  
5 ophthalmologist, Dr. David Turok. Neither examined Mr. Walker directly. Dr. Rosenberg  
6 concluded that the file showed Mr. Walker was obese, diabetic, and suffered from some heart  
7 disease. He opined that Mr. Walker "would be capable of medium work on a full time basis"  
8 (*id.* at 244). Dr. Turok stated Mr. Walker's level of functionality was not restricted by blurred  
9 or monocular vision. He reported that Mr. Walker was well-controlled with his current  
10 medications.

11 In March 2007, MetLife faxed the medical reviewers' reports to Dr. Chuang and  
12 Dr. Jones. Dr. Chuang responded in April 2007, stating Mr. Walker's "ophthalmologic  
13 involvement (diabetic retinopathy) from his diabetes is problematic for him to function normally.  
14 His retinopathy will only get worse." Dr. Chuang also indicated Mr. Walker's "functionality  
15 is significantly limited by the edema in his lower legs caused by [congestive heart failure],  
16 vasodilating medications and as well as significant pain from the diabetes neuropathy."  
17 Dr. Chuang stated that "[w]ith combination of [Mr. Walker's] ophthalmologic involvement,  
18 edema of his lower extremities and pain from diabetes neuropathy in addition to his complicated  
19 medical history . . . I will strongly advise you to reconsider his claim to disability" (*id.* at 238).

20 Dr. Rosenberg called Dr. Chuang to discuss Mr. Walker's medical condition. Dr.  
21 Chuang did not respond. Dr. Rosenberg then provided a supplemental report stating nothing had  
22 changed his opinion about Mr. Walker's ability to perform medium-level work. MetLife  
23 submitted further questions to Dr. Rosenberg and Dr. Turok, inquiring whether Mr. Walker's  
24 medications caused functional impairment. Both doctors answered that they did not.

25 In June 2007, MetLife concluded Mr. Walker was capable of performing his own job and  
26 that the medical documentation did not show he was disabled throughout the elimination period.  
27 Accordingly, MetLife informed Mr. Walker that it had denied his appeal. Mr. Walker had  
28 exhausted his administrative remedies.

\* \* \*

1  
2 In July 2007, Mr. Walker sued defendants under ERISA, 29 U.S.C 1132(a), (e), (f), and  
3 (g), claiming MetLife abused its discretion in denying his claim. In January 2008, defendants  
4 moved for summary judgment. In opposition thereto, Mr. Walker requested further discovery  
5 on the grounds that MetLife knowingly relied on biased NMR reviewers and operated under a  
6 structural conflict of interest in denying his claim as MetLife both funded and determined  
7 eligibility for plan benefits. The Court granted Mr. Walker limited discovery on these issues.

8 In April 2008, the parties requested that the discovery completion date be stayed and the  
9 briefing schedule continued pending the outcome of the Supreme Court's decision in  
10 *Metropolitan Life Insurance Co. v. Glenn*, \_\_\_ U.S. \_\_\_, 128 S.Ct. 2343 (2008), wherein two issues  
11 had been accepted for review: (i) whether the Sixth Circuit had erred in holding, in conflict with  
12 two other circuits, that the fact that a claim administrator of an ERISA plan also funds the plan  
13 benefits, without more, constituted a "conflict of interest" which must be weighed in a judicial  
14 review of the administrator's benefit determination under *Firestone Tire & Rubber v. Brunch*,  
15 489 U.S. 101 (1989); and (ii) where an administrator that both determines and pays claims under  
16 an ERISA plan is deemed to be operating under a conflict of interest, how that conflict should be  
17 taken into account on judicial review of a discretionary benefit determination. Because the  
18 parties had already moved so far along with discovery, the request to stay discovery was denied.  
19 Because it was possible, however, that *Glenn* could influence the motions for summary  
20 judgment, the request to continue the briefing schedule was granted.

21 Thereafter, defendants renewed their motion for summary judgment on the ground  
22 that MetLife did not abuse its discretion in denying benefits to Mr. Walker. Mr. Walker has  
23 cross-moved for summary judgment maintaining MetLife conducted a biased claims  
24 investigation, failed to conduct a full and fair review, and abused its discretion in denying him  
25 disability benefits.

### ANALYSIS

26  
27 ERISA's purpose is "to protect . . . the interests of participants in employee benefit plans  
28 and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries

1 of financial and other information with respect thereto, by establishing standards of conduct,  
2 responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for  
3 appropriate remedies, sanctions, and ready access to the Federal courts.” 29 U.S.C. 1001(b).

4 Just three months ago, the Supreme Court explained in *Glenn*, 128 S.Ct. at 2350:

5 ERISA imposes higher-than-marketplace quality standards on  
6 insurers. It sets forth a special standard of care upon a plan  
7 administrator, namely, that the administrator “discharge [its]  
8 duties” in respect to discretionary claims processing “solely in the  
9 interests of the participants and beneficiaries” of the plan, §  
10 1104(a)(1); it simultaneously underscores the particular  
11 importance of accurate claims processing by insisting that  
12 administrators “provide a ‘full and fair review’ of claim denials,”  
13 (quoting § 1133(2)); and it supplements marketplace and  
14 regulatory controls with judicial review of individual claim  
15 denials, *see* § 1132(a)(1)(B).<sup>1</sup>

16 Judicial review under ERISA is provided for in section 1132(a)(1)(B) which states that a  
17 participant in an employee benefit plan may bring a civil action “to recover benefits due to him  
18 under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his  
19 rights to future benefits under the terms of the plan.”

20 The Supreme Court addressed the standard of judicial review of benefit determinations  
21 by fiduciaries or plan administrators under ERISA in *Glenn*, wherein it elucidated what it had  
22 earlier set forth in *Firestone*. *Firestone*, 489 U.S. at 115, provided that principles of trust law  
23 require courts to review a denial of plan benefits “under a *de novo* standard” unless the plan  
24 provides to the contrary. Where the plan provides to the contrary by granting “the administrator  
25 or fiduciary discretionary authority to determine eligibility for benefits,” *ibid*. “[t]rust principles  
26 make a deferential standard of review appropriate,” *id*. at 111. Furthermore, where “a benefit  
27 plan gives discretion to an administrator or fiduciary who is operating under a conflict of  
28 interest, that conflict must be weighed as a ‘factor in determining whether there is an abuse of  
discretion.’” *Id*. at 115.

*Glenn*, 128 S.Ct. at 2348, held that “the kind of ‘conflict of interest’ to which [*Firestone*]  
refers” includes cases in which “a plan administrator both evaluates claims for benefits and pays

---

<sup>1</sup> Unless indicated otherwise, internal citations are omitted from all quoted authorities in this order.

1 benefits claims.” *Glenn, id.* at 2350, provided the following guidance for evaluating the conflict  
2 of interest factor:

3 We turn to the question of how the conflict we have just identified  
4 should be taken into account on judicial review of a discretionary  
5 benefit determination. In doing so, we elucidate what this Court  
6 set forth in *Firestone*, namely, that a conflict should be weighed as  
7 a factor in determining whether there is an abuse of discretion.  
8 We do not believe that *Firestone*’s statement implies a change in  
9 the standard of review, say, from deferential to de novo review . . .  
10 Neither do we believe it necessary or desirable for courts to create  
11 special burden-of-proof rules, or other special procedural  
12 evidentiary rules, focused narrowly upon the evaluator/payor  
13 conflict . . . We believe that *Firestone* means what the word  
14 “factor” implies, namely, that when judges review the lawfulness  
15 of benefit denials, they will often take account of several different  
16 considerations of which a conflict of interest is one.

17 The Ninth Circuit recently noted that *Glenn* endorsed the approach it had adopted in  
18 *Abatie v. Alta Life & Health Ins. Co.*, 458 F.3d 955 (9th Cir. 2006) (en banc). *Wilcox v. Wells*  
19 *Fargo & Co. Long Term Disability Plan*, 2008 WL 2873735, at \*1 (9th Cir. 2008); *see also*  
20 *Hoskins v. Bayer Corp.*, 564 F. Supp. 2d 1097, 1103 (N.D. Cal. 2008) (stating no inconsistency  
21 found between *Abatie* and *Glenn*). Like *Glenn*, *Abatie* held that a conflict of interest must be  
22 weighed as a factor in abuse of discretion review. *Abatie*, 458 F.3d at 959, 968, also held that a  
23 court should temper its abuse of discretion review with “skepticism commensurate with the  
24 plan administrator’s conflict of interest” taking into account “all the circumstances before it.”  
25 It noted, *id.* at 968–969:

26 The level of skepticism with which a court views a conflicted  
27 administrator’s decision may be low if a structural conflict of  
28 interest is unaccompanied, for example, by any evidence of malice,  
of self-dealing, or of a parsimonious claims-granting history. A  
court may weigh a conflict more heavily if, for example, 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.

Similarly, *Glenn*, 128 S.Ct. at 2351, explained that the conflict of interest should prove  
more important where circumstances suggest a higher likelihood that it affected the benefits  
decision, including, but not limited to, cases where an insurance company administrator has a

1 history of biased claims administration; it should prove less important where the administrator  
2 has taken active steps to reduce potential bias and to promote accuracy.

3 *Abatie*, 458 F.3d at 969, recognized that weighing a conflict as a factor in an abuse of  
4 discretion review is indefinite, but stated:

5 We believe, however, that trial courts are familiar with the process  
6 of weighing a conflict of interest. For example, in a bench trial the  
7 court must decide how much weight to give to a witness'  
8 testimony in the face of some evidence of bias. What the district  
9 court is doing in an ERISA benefits denial case is making  
10 something akin to a credibility determination about the insurance  
11 company's or plan administrator's reason for denying coverage  
12 under a particular plan and a particular set of medical and other  
13 records. We believe that district courts are well equipped to  
14 consider the particulars of a conflict of interest, along with all the  
15 other facts and circumstances, to determine whether an abuse of  
16 discretion has occurred.

17 *Abatie* also noted that this "careful, case-by-case approach . . . alleviates the unreasonable  
18 burden" placed on ERISA plaintiffs in precedent such as *Jordan v. Northrop Grumman Corp.*  
19 *Welfare Benefit Plan*, 370 F.3d 869 (9th Cir. 2004), wherein the influence of an administrator's  
20 conflict would be considered only if the plaintiff brought forth evidence of a serious conflict,  
21 thereby triggering *de novo* review; otherwise, the administrator's denial of benefits would be  
22 upheld "so long as it was grounded on *any* reasonable basis." *Ibid.* (quoting *Jordan*, 370 F.3d  
23 at 875) (emphasis in original). *Abatie* held that going forward, "[p]laintiffs will have the benefit  
24 of an abuse of discretion review that always considers the inherent conflict when a plan  
25 administrator is also the fiduciary, even in the absence of 'smoking gun' evidence of conflict."  
26 *Ibid.*

27 *Abatie* advised that, given this closer scrutiny, conflicted administrators "may find it  
28 advisable to bring forth affirmative evidence that any conflict did not influence its  
decisionmaking process, evidence that would be helpful to determining whether or not it has  
abused its discretion." *Ibid.* It might, for example "demonstrate that it used truly independent  
medical examiners[.]" *Id.* at 969 n.7.

\* \* \*

1 Here, the employee welfare-benefit plan gave MetLife, the plan administrator, the  
2 discretion to make claim determinations. The umbrella plan document, “Kaiser Permanente  
3 Welfare Benefits Plan,” provided, in relevant part:

4 4.1 Named Fiduciaries. The named fiduciaries with respect to  
5 each Plan, for purposes of ERISA, shall be the Employers whose  
6 employees participate in such Plan. With respect to each Program  
7 in which benefits are provided under a Contract in which the  
8 Insurer is responsible for review of the benefit claim  
9 determination, such Insurer is the named fiduciary with respect to  
10 such determinations, pursuant to ERISA Regulation § 2560.503-  
11 1(g)(2).

12 In addition, the Employer may identify further named  
13 fiduciaries by (i) notifying such person(s) in writing of its  
14 designation or (ii) allocating or delegating fiduciary  
15 responsibilities to such person under Section 4.2.

16 4.2 Allocation and Delegation of Fiduciary Responsibility  
17 a. Each Named Fiduciary is allocated fiduciary responsibility  
18 with respect to the specific discretionary authority  
19 exercised by it, under the Contract(s) relating to the  
20 Program(s) in which such Named Fiduciary participates.

21 \* \* \*

22 4.4 Discretionary Authority of Fiduciaries. Each Named  
23 Fiduciary, and each person to whom fiduciary authority  
24 shall have been allocated or delegated under Section 4.2,  
25 shall have full and complete discretionary authority with  
26 respect to its responsibilities under the Plan and any  
27 Program hereunder. All actions, interpretations, and  
28 decisions of a Named Fiduciary or a delegate thereof shall  
be conclusive and binding on all persons and shall be given  
the maximum possible deference allowed by law.

(AR 7). Mr. Walker does not dispute that the plan conferred  
discretion on MetLife.

In addition to conferring discretion on MetLife, the plan named MetLife as claim  
administrator and payor,<sup>2</sup> thereby creating a structural conflict of interest. MetLife does not  
dispute this. Accordingly, this order reviews MetLife’s claim determination for abuse of  
discretion, taking into account MetLife’s structural conflict of interest as compounded by its

---

<sup>2</sup> This dual role is acknowledged in the Summary Plan Description which states, “MetLife is the insurer and third party administrator for the Employee life, Dependent life and Long-Term Disability insurance plans . . . In the event of a Long-Term Disability, you must also provide this information to MetLife, the administrator for Long-Term Disability claims” (AR 163-64). In short, MetLife both funded the benefits to be paid under the Plan and, as claim administrator, determined eligibility for benefits.

1 reliance on NMR. In so doing, the parties' respective motions for summary judgment will be  
2 construed as motions for judgment under FRCP 52, in order that the Court may weigh evidence  
3 relevant to the conflict of interest bearing on MetLife's exercise of discretion, as it is required to  
4 do under *Glenn* and *Abatie*.

5 \* \* \*

6 MetLife argues that its decision to deny Mr. Walker's claim for long-term disability  
7 benefits must be upheld because no abuse of discretion on its part is evidenced in the  
8 administrative record. MetLife maintains that, in reviewing Mr. Walker's claim and generating  
9 the administrative record, it obtained medical opinions from appropriate sources and gave  
10 Mr. Walker multiple opportunities to provide his side of the story. MetLife states that "[t]his is  
11 hardly the picture of a conflicted administrator putting its own interests ahead of its duty to  
12 evaluate claims fully and fairly" (Defendants' Opp. 12).

13 MetLife is correct that the administrative record lacks evidence that its conflict of interest  
14 adversely influenced its exercise of discretion in this case. Critical gaps in the record, however,  
15 render it insufficient to properly vet the effect of MetLife's conflict. Most importantly, the  
16 record was developed and the decision was made largely in reliance upon NMR, a company  
17 MetLife knows benefits financially from doing repeat business with it. NMR received more  
18 than \$11 million from MetLife between 2002 and 2007 (Green Decl., Exh. B at 4). It follows  
19 that MetLife knows NMR has an incentive to provide it with reports upon which MetLife may  
20 rely in justifying its decision to deny benefits in order to increase the chances that MetLife will  
21 return to NMR in the future.

22 Key to determining whether MetLife's conflict of interest, compounded by its reliance on  
23 a company with an incentive to provide it biased reports, led to a "parsimonious claims granting  
24 history" in the words of *Abatie* or a "history of biased claims administration" in the words of  
25 *Glenn*, is statistical information regarding NMR physician reviews relied upon by MetLife in  
26 making its disability claim determinations. When Mr. Walker sought to obtain this information  
27 through discovery, however, MetLife contended that neither it nor NMR maintained such "track  
28 record" information and that generating it would be too burdensome and expensive.

1 In support of its contention of undue burden and expense, MetLife provided Mr. Walker  
2 with its responses to interrogatories propounded by a different plaintiff in a different ERISA  
3 action pending before the Northern District of California, *Dilley v. MetLife*, Case No. 07-01831  
4 PJH (N.D. Cal.). Therein MetLife was asked to provide figures including the number of claims  
5 it had referred to NMR since 2002 and the number of claims it had denied based, in whole or in  
6 part, upon NMR reviews. As to the number of claims referred to NMR, MetLife stated it  
7 referred 3,593 claims in 2007, 3,159 claims in 2006, and 2,304 claims in 2005. MetLife declined  
8 to provide referral statistics for prior years on the ground that it was unduly burdensome and  
9 expensive because the information before 2005 was maintained on microfilm. As to the number  
10 of claims denied in reliance on NMR reviews, MetLife provided no statistics at all, stating it was  
11 unduly burdensome and expensive as it would require an estimated 2,264 hours of worker time  
12 to compile the information for years 2005 through 2007 alone.

13 Though MetLife provided its responses to the *Dilley* interrogatories in order to support its  
14 contention that producing the information was unduly burdensome and expensive, it has  
15 likewise, albeit inadvertently, underscored the demand for transparency regarding its  
16 claims-granting history in reliance on NMR. Counsel points to yet another case in which an  
17 insurer refused to produce information regarding the track record of its reliance on NMR  
18 reviewing physicians, *Denmark v. Liberty Life Assur. Co. of Boston*, 2005 WL 3008684  
19 (D. Mass.). There, the court ordered the insurer to stipulate to the number of claims it had  
20 accepted or granted and rejected or denied after a review by a physician retained through NMR.  
21 When the insurer refused to comply due to “burden and expense,” the *Denmark* court drew an  
22 inference that NMR physicians had not found in favor of a single claimant referred for review by  
23 the insurer to NMR during the years in question. MetLife opposes any similar inference in this  
24 case stating no such order for production was issued or is warranted.

25 MetLife is mistaken that such an order is not warranted. *First*, without this information,  
26 the influence of MetLife’s conflict of interest as compounded by its reliance on NMR cannot  
27 readily be determined from the record at hand. *Second*, producing this information is consistent  
28 with the Ninth Circuit’s advice to conflicted administrators in *Abaite* “to bring forth affirmative

1 evidence that any conflict did not influence its decisionmaking process, evidence that would be  
2 helpful to determining whether or not it has abused its discretion.” *Abatie*, 458 F.3d at 969.  
3 It might, for example “demonstrate that it used truly independent medical examiners[.]” *Id.* at  
4 969 n.7. *Third*, in light of *Glenn* and *Abatie*, the demand for such statistics elucidating the  
5 influence of insurer conflicts of interest will only grow. While this order does not doubt  
6 MetLife’s contention that producing such information will be costly, in the short run, the  
7 sooner it is able to readily generate such information the greater its savings will be, in the long  
8 run, via shortened discovery disputes and, if no conflict is shown, reduced litigation on this  
9 point. The public too, will be spared the expense of undue court congestion on these issues.

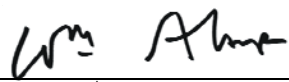
10 Accordingly, MetLife is hereby ordered, **WITHIN THIRTY DAYS**, to state under order the  
11 number of claims it has accepted or granted and rejected or denied after a review by a physician  
12 retained through NMR from 2005 through 2007. Absent such an answer, this Court will infer  
13 that MetLife has not granted a single claim in which NMR reviews were obtained. A trial will  
14 then be required in order to fully vet MetLife’s exercise of discretion and the role played by its  
15 conflict therein.

16 **CONCLUSION**

17 For the foregoing reasons, the parties’ cross-motions for summary judgment are  
18 **DENIED** and MetLife is ordered to produce, **WITHIN THIRTY DAYS**, the information described in  
19 the court-ordered interrogatory propounded above.

20  
21 **IT IS SO ORDERED.**

22  
23 Dated: November 10, 2008.

24   
25 \_\_\_\_\_  
26 WILLIAM ALSUP  
27 UNITED STATES DISTRICT JUDGE  
28