No. 18-1266

In The
Supreme Court of the United States

TIMOTHY P. O'LEARY,

Petitioner,

v.

AETNA LIFE INSURANCE COMPANY,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF IN OPPOSITION TO PETITION FOR CERTIORARI

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RESTATEMENT OF QUESTIONS PRESENTED

I. Whether Petitioner has presented compelling reasons to grant certiorari, where Petitioner has mischaracterized the facts of the case and the holding of the appeals court below.

II. Whether Petitioner has presented compelling reasons to grant certiorari, where no violation of any applicable statutory or regulatory requirement was found by the lower courts.

III. Whether Petitioner has presented compelling reasons to grant certiorari, where no holding of the appeals court below is in conflict with any holding of another circuit court of appeals or any holding of this Court.

IV. Whether Petitioner has presented compelling reasons to grant certiorari, where no important federal question was decided by the appeals court below.

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INTRODUCTION

This is a dispute over disability insurance benefits governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq*. ("ERISA"). Petitioner brought suit in the district court to overturn Respondent's decision, as a claim administrator for an employee welfare benefit plan, to discontinue benefits based on its determination that he had ceased to be eligible for them under the terms of the applicable policy (the "Policy"). After the parties filed cross-motions for summary judgment, the district court denied Petitioner's motion and entered summary judgment in favor of Respondent. Petitioner then appealed to the Eleventh Circuit, which affirmed the judgment in an unpublished opinion.

Petitioner fails to present any compelling reason to grant certiorari. Instead, he attributes to the Eleventh Circuit a holding that is neither stated nor implied in the panel's unpublished opinion, for the purpose of conjuring an illusory "circuit split" between the Eleventh Circuit and other circuits that have allegedly held to the contrary. All of Petitioner's arguments depend, moreover, on this Court's acceptance of a false premise, namely that Respondent in deciding his benefits claim violated requirements set forth in ERISA and its implementing regulation. In reality, however, neither the district court nor the appeals court found any such violation, and it is not the practice of this Court to make such findings in the first instance. Consequently, no compelling basis for this

Court's review is presented, and the Petition should be denied.

STATEMENT OF THE CASE

In 2006, Petitioner was injured in a motorcycle accident. Pet. App. 2. At the time of the accident, Petitioner was employed as the Director of Information Technology for the New England Regional Council of Carpenters. *Id*. The New England Regional Council of Carpenters participated in the Association of Community Service Agencies' Group Insurance Trust, which had a long-term disability insurance policy (the "Policy") with coverage underwritten by Respondent. *Id*.

Under the terms of the Policy, a claimant is entitled to benefits for a period of up to 24 months if he is incapable of performing the material duties of his occupation due to disease or injury. *Id.* A claimant is entitled to additional benefits beyond the initial 24-month period if he is incapable of working in "any reasonable occupation." *Id.* The Policy gives Respondent "discretionary authority to determine whether and to what extent employees and beneficiaries are entitled to benefits; and construe any disputed or doubtful terms of this Policy." *Id.*

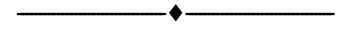
After the accident, Petitioner filed a claim with Respondent for long-term disability benefits. *Id.* Respondent approved Petitioner's claim and he received the full 24 months of own-occupation benefits, followed by additional benefits under the "any reasonable

occupation" disability definition. In 2015—approximately nine years after the motorcycle accident—Respondent decided to terminate Petitioner's benefits. *Id*. Respondent informed Petitioner that the evidence in its file no longer supported a conclusion that he was entitled to benefits under the Policy. *Id*. Respondent explained that it had commissioned surveillance on Petitioner, which showed that he was able to drive, tote a garbage can to his garage, and dance at a nightclub. Pet. App. 3-4. Respondent also indicated that its decision was based on the opinion of an independent physician who had reviewed Petitioner's medical records and spoken with Petitioner's physician. Pet. App. 4. Petitioner appealed the termination of his benefits and submitted additional medical records to Respondent. *Id.* After receiving the records, Respondent requested independent peer reviews from multiple consulting physicians. *Id*. Those physicians opined that Petitioner's medical records, together with the surveillance evidence, showed he was no longer functionally impaired. *Id.* After considering all the evidence before it on appeal, Respondent upheld the decision to terminate benefits based on the surveillance evidence and the peer reviews. *Id*.

Petitioner then filed suit in federal district court challenging Respondent's decision. Respondent and Petitioner filed cross motions for summary judgment. Commenting that this was "not a close case" in view of the activity level documented by the surveillance, the district court entered summary judgment in favor of

Respondent on the ground that the benefits termination decision was "reasonable and not arbitrary and capricious." Pet. App. 27, 30. At no time in the district court proceeding did Petitioner contend that Respondent violated 29 U.S.C. § 1133 (the provision of ERISA entitling claimants to receive a full and fair review on appeal following an adverse benefits determination) or 29 C.F.R. § 2560-503.1 (the Department of Labor regulation that implements the statutory requirement of a full and fair review). More specifically, Petitioner did not contend Respondent violated § 2560-503.1 by failing to review his appeal in consultation with an appropriately qualified healthcare professional, as that regulatory provision requires. Consequently, no finding of any violation was made by the district court.

Petitioner then appealed the summary judgment to the Eleventh Circuit, contending that Respondent had improperly weighed the investigative and medical evidence. The Eleventh Circuit agreed with the district court and affirmed the judgment, concluding that "we cannot say that [Respondent's] decision to deny benefits was unreasonable or arbitrary and capricious given the surveillance video and the physician's assessments contained in the administrative record." Pet. App. 11. Petitioner on appeal did not assert any violation by Respondent of either 29 U.S.C. § 1133 or 29 C.F.R. § 2560-503.1, and no such violation was found by the appeals court.



REASONS FOR DENYING THE PETITION

The exercise of certiorari jurisdiction is a matter of judicial discretion, and a writ of certiorari is granted only for "compelling reasons." Sup. Ct. R. 10. A compelling reason exists when a United States court of appeals has entered a decision that conflicts with another court of appeals' decision regarding an important matter, or decided an important federal question in a way that conflicts with a decision by a state court of last resort, or "so far departed from the accepted and usual course of judicial proceedings" as to require the exercise of the Supreme Court's supervisory power. *Id*. Certiorari is also properly granted when a court of appeals has "decided an important question of federal law that has not been, but should be, settled by this Court, or has decided an important federal question in a way that conflicts with relevant decisions of this Court." *Id*.

As Supreme Court Rule 10 makes clear, the exercise of certiorari jurisdiction is predicated on the substance of a decision by a court of appeals. Accordingly, the Supreme Court does not consider matters that were not decided by the court of appeals in a given case. *Meyer v. Holley*, 537 U.S. 280, 291-92, 123 S.Ct. 824 (2003) (refusing to consider matters that the court of appeals "did not decide"). Here, the Eleventh Circuit decided (1) that it would assume for purposes of the appeal that Respondent's decision to terminate benefits was "*de novo* wrong," (2) that the Policy vested Respondent with discretion in reviewing claims, (3) that reasonable grounds supported the decision to terminate benefits, (4) that Respondent had a structural

conflict of interest as defined by applicable law because it determined eligibility for benefits which it paid out of its own funds, and (5) that even with Respondent's conflict of interest considered as a factor in the analysis, the court could not say the discretionary benefits decision was arbitrary and capricious in view of the reasonable grounds supporting it.[1] Pet. App. 6-11. The court of appeals decided nothing else.

In framing the questions presented for review, Petitioner misrepresents to this Court that the Eleventh Circuit (1) deemed Respondent to have been in violation of applicable statutory and regulatory provisions during the administration of Petitioner's disability claim, and then (2) upheld the benefits decision out of deference to Respondent's discretionary authority despite the company's statutory and regulatory infractions. In Petitioner's formulation, this alleged ruling puts the Eleventh Circuit at odds with other circuits that have accorded different treatment to statutory and/or regulatory violations by an ERISA claim administrator, thus creating an alleged "circuit split" concerning an important issue of federal law. Fatally for the Petition, however, none of this actually occurred.

As a review of the lower court opinions appended to the Petition will confirm, neither the district court

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[1] In reaching these conclusions, the appeals court panel correctly employed the multi-step analysis courts in the Eleventh Circuit are required to conduct in ERISA benefits cases. *See* Pet. App. 5-6 (setting forth the sequential stages of the required analysis as stated in *Blankenship v. Metro. Life Ins. Co.*, 644 F.3d 1350, 1355 (11th Cir. 2011)).

nor the court of appeals made any finding or determination whatsoever concerning any alleged failure by Respondent to comply with any applicable provision of ERISA or its implementing procedural regulation, 29 C.F.R. § 2560-503.1. More specifically, there was no finding that Respondent failed to comply with the requirement that a claimant's appeal be decided in consultation with an appropriately qualified healthcare professional, as Petitioner now contends. Since no statutory or regulatory violation was alleged or considered, the Eleventh Circuit did not, as Petitioner claims, make any determination that Respondent's discretionary authority was entitled to judicial deference despite such violation. There is thus no conflict between the decision below and any decision of any other court with respect to the legal significance of a statutory or regulatory violation by an ERISA claim administrator. Accordingly, certiorari should be denied. *Bunting v. Mellen*, 541 U.S. 1019, 1021, 124 S.Ct. 1750 (2004) (denying certiorari due to the "absence of a direct conflict among the circuits").

By the same sound logic, it is clear the Eleventh Circuit decided no issue of importance with respect to violations of ERISA or its implementing regulation by a claim administrator. Indeed, it made no decision at all regarding any such matters, and neither did the district court. As the questions presented by Petitioner were not litigated in the lower courts, they are not suitable for this Court's review. *Apodaca v. Raemisch*, 139 S.Ct. 5, 7 (2018) (Sotomayor, J., concurring in denial of certiorari) (commenting that since the "litigation

before the lower courts did not focus on" the issue raised by petitioner, the case was "not well suited to our considering the question now"). Although Petitioner implicitly urges this Court to find that a statutory or regulatory violation occurred in the instant case, his allegations are emphatically denied by Respondent, and it is "not this Court's practice to adjudicate either legal or predicate factual questions in the first instance." *CRST Van Expedited, Inc. v. E.E.O.C.*, 136 S.Ct. 1642, 1653 (2016). Any attempt to adjudicate Respondent's compliance with applicable law in its administration of Petitioner's disability claim would necessarily be highly fact-specific, and this Court "generally do[es] not grant [certiorari] review to decide highly fact-specific questions." *Kennedy v. Bremerton School Dist.*, 139 S.Ct. 634, 636 (2019) (Alito, J., concurring in denial of certiorari).

The lower courts in the instant case decided only that Respondent's decision to terminate ERISA-governed disability benefits was not "arbitrary and capricious" given the reasonable grounds supporting the decision. The questions presented by Petitioner for this Court's review were not litigated below, and no aspect of the Eleventh Circuit's decision to affirm the judgment even arguably conflicts with any decision of another circuit—or of this Court—concerning those issues. The Eleventh Circuit simply did not make the decision Petitioner insists it made. Furthermore, no violation of law by Respondent was found by the lower courts and none in fact occurred. This Court should therefore reject Petitioner's attempt to present the

instant case as "certworthy" based on unsupported and inaccurate assertions.

CONCLUSION

Petitioner has not presented any compelling reason for this Court to grant certiorari. Therefore, Respondent respectfully requests that the Petition be denied.

Respectfully submitted,

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