No. 20-1106

IN THE

Supreme Court of the United States

JANE DOE,

Petitioner,

v.

HARVARD PILGRIM HEALTH CARE, INC. AND THE HARVARD PILGRIM PPO PLAN MASSACHUSETTS, GROUP POLICY NUMBER 0588660000,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether the district court correctly granted summary judgment denying petitioner's claim for benefits under the Employee Retirement Income Security Act, 29 U.S.C. § 1132(a)(1)(B), where petitioner agreed that summary judgment was the correct vehicle for adjudicating her claim and did not argue that any evidence was improperly omitted from the record.

CORPORATE DISCLOSURE STATEMENT

Harvard Pilgrim Health Care, Inc.'s corporate parent is Health Plan Holdings, Inc., a nonprofit holding company. No publicly held company owns more than 10% of its stock.

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INTRODUCTION

Jane Doe's petition for certiorari bears little resemblance to the case Doe presented and the courts decided below. Doe brought this action under the Employee Retirement Income Security Act, 29 U.S.C. § 1132(a)(1)(B), to challenge respondent Harvard Pilgrim Health Care, Inc.'s denial of her claim for benefits under an employee health-benefit plan. The case turned on whether Doe's four-month stay in residential treatment for mental illness was "medically necessary" as that term is defined in the Harvard Pilgrim plan. Upon de novo review, the district court concluded that it was not. The court of appeals affirmed.

Consistent with a prior decision in Doe's favor by the court of appeals, the district court granted summary judgment to Harvard Pilgrim based on an expanded administrative record that included all of the evidence Harvard Pilgrim had before it when it made its coverage decision. In Doe's second appeal, which is the subject of the present petition, Doe did not contend that any material was "improperly omitted from the record" or that the district court erred in "defining the record to be reviewed." Pet. App. 10a. Doe's sole procedural claim was that the district court should have heard live testimony from medical experts whose opinions were already in the record—a hearing that, in Doe's view, might have assisted the court in resolving the parties' cross-motions for summary judgment, which Doe agreed was the correct vehicle for adjudicating her claim. Consistent with Doe's concession that such a hearing is not required in every case, the district court found it unnecessary to hold a hearing. The court of appeals found no error in that decision.

Before this Court, Doe now attempts to latch her case onto what she contends are two "intractable" circuit splits concerning procedures for adjudicating ERISA denial-of-benefits claims. That effort fails. As to both questions presented, Doe overstates the existence and the importance of divergence among the circuits. All circuits agree that in an ERISA denial-of-benefits case where the plan does not give the fiduciary discretion to determine eligibility for benefits, the district court should review the denial of benefits de novo, *see Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 115 (1989), and that doing so requires the court to weigh the evidence, draw reasonable inferences, resolve conflicts in the factual record, and render an independent judgment as to whether the plaintiff met his

or her burden of proof. Whether that review is called "summary judgment" or a "bench trial" or is given some other label, the substantive review is the same. Doe cites no basis to think the circuits' different nomenclature for review of plans' decisions makes any difference to whether an ERISA claimant wins or loses. It certainly made no difference here, where the district court entered summary judgment after making an independent, de novo determination based on the totality of the record.

Doe suggests that the procedural posture might matter in cases where a court agrees to consider evidence outside the administrative record; but as to that issue, virtually all of the courts of appeals agree that district courts have some discretion to determine, on a case-by-case basis, whether to admit new evidence. Here, Doe did not ask the district court to do so. Although she argued that the district court would "benefit" from live testimony of the medical experts whose written reports appeared in the record, she stressed that such a hearing would "not be a vehicle for introducing new evidence." Dist. Ct. Dkt. 100 at 11-12.

At bottom, Doe seeks factbound error correction where there is no error in the guise of two procedural arguments, neither of which would make a difference to the outcome and neither of which would warrant review in its own right. The petition should be denied.

STATEMENT

A. The Harvard Pilgrim Plan And Denial Of Doe's Claim

Harvard Pilgrim is a nonprofit sponsor of employee health benefit plans, including the plan that covered Jane Doe (the "Plan"). The Plan provides coverage for

treatment that is "medically necessary," a term defined in the Plan's benefit handbook. Pet. App. 26a. To be considered medically necessary, treatment must be "the most appropriate … level of service for the Member's condition, considering the potential benefit and harm to the individual." Pet. App. 5a, 36a.

The Plan includes coverage for mental-health benefits. Harvard Pilgrim contracts with United Behavioral Health ("UBH") to manage those benefits and make initial coverage determinations under guidelines established by UBH to determine medical necessity.

Doe was a dependent beneficiary of a Plan participant. In 2012, Doe began experiencing symptoms of mental illness. On January 17, 2013, Doe was admitted to the Austen Riggs Center ("Riggs") in Stockbridge, Massachusetts, for residential mental-health treatment, for which she sought coverage under the Plan. As relevant here, the UBH guidelines provide that residential mental-health treatment is medically necessary when:

> [1] The [Plan] member is experiencing a disturbance in mood, affect or cognition resulting in behavior that cannot be safely managed in a less restrictive setting[,] –OR– [2] [t]here is an imminent risk that severe, multiple and/or complex psychosocial stressors will produce significant enough distress or impairment in psychological, social, occupational/educational, or other important areas of functioning to undermine treatment in a lower level of care.

Pet. App. 6a.[1]

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[1] Under a third test not relevant here, residential treatment may also be medically necessary if the member has a co-occurring

UBH initially approved coverage for Doe for seven days of residential treatment at Riggs, through January 24, 2013. Pet. App. 27a-28a; C.A.J.A. 350-351. Doe "responded well" to medication. Pet. App. 40a. Doe reported "'feeling better'" and began to engage with peers at Riggs and repeatedly left the Riggs campus, including to go shopping and visit an art store. Pet. App. 21a.

In the meantime, a UBH clinician reviewed Doe's claim. After consulting with Doe's treating psychologist, Dr. Sharon Krikorian, UBH concluded that Doe "could be readied to step down to partial hospitalization" and that continued residential care was no longer medically necessary. Pet. App. 28a. UBH approved an extension of coverage to February 5 to allow time to prepare a discharge plan. *Id.*

On February 4, 2013, UBH's Associate Medical Director, Dr. James Feussner, conducted a further review of the medical necessity of Doe's residential treatment. Pet. App. 28a-29a. Although Dr. Krikorian had recommended four to six more weeks at Riggs, she also reported that Doe was not actively suicidal or psychotic, that her condition had improved with medication, and that her medications had not needed to be adjusted for two weeks. *Id.* Dr. Feussner concluded that residential treatment at Riggs was no longer medically necessary because the "'acute crisis'" for which Doe was originally admitted had "'quieted,'" and Doe "'[did] not appear to need further help from residential level of care.'" Pet. App. 29a. Relying on Dr. Feussner's assessment, UBH denied coverage for continuing residential treatment, advising that Doe could seek care

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disorder that would complicate treatment outside a residential setting. Pet. App. 6a.

through a partial-hospitalization program. *Id.*; C.A.J.A. 523-527.

Doe sought an expedited appeal. Pet. App. 29a-30a. A board-certified psychiatrist, Dr. Michael Bennett, who had not participated in any prior review, conducted the review. Dr. Bennett considered Doe's medical history and the case notes from Doe's stay at Riggs and consulted with Dr. Krikorian. Pet. App. 30a. Although Doe continued to show some symptoms, Dr. Bennett concluded that continued residential treatment was not medically necessary because Doe could safely "'pursue treatment while living at home and attending outpatient treatment, beginning with [partial-hospitalization programs].'" *Id.* Relying on Dr. Bennett's review, Harvard Pilgrim denied Doe's appeal. *Id.*; C.A.J.A. 529-532. The denial letter explained that Harvard Pilgrim was upholding the denial of coverage for residential treatment but would cover Doe's stay at Riggs during the pendency of her appeal, through February 12, 2013. *Id.*

Doe remained at Riggs and appealed to the Massachusetts Department of Mental Health's Office of Patient Protection ("OPP"). Pet. App. 30a. Pursuant to OPP's regulations, an anonymous, independent board-certified psychiatrist described as an assistant clinical professor of psychiatry and medical director of child and adolescent services at a university-affiliated psychiatric hospital was appointed by OPP to review Doe's claim. Applying the UBH guidelines, the anonymous expert reviewed Doe's medical history, including prior hospitalizations and medical records from Riggs, and concluded that as of February 13, 2013, there was "'no evidence that [Doe] required 24 hour supervision or nursing care.'" Pet. App. 30a-31a. By that time, Doe denied suicidal or homicidal ideation, and there was no

evidence in the medical record that her continuing symptoms were "severe enough to prevent [Doe] from participating in treatment at a lower level of care such as a [partial-hospitalization program] or make treatment at a lower level of care … unsafe." Pet. App. 31a. On March 12, 2013, OPP informed Doe that the independent reviewer had affirmed Harvard Pilgrim's coverage determination in full. Pet. App. 30a-31a.

Despite that decision and the availability of coverage for partial hospitalization, Doe remained at Riggs until June 18, 2013, when she was transferred to another facility for acute inpatient care. On June 24, 2013, Doe returned to Riggs for a second stay until August 7, 2013. Based on a report by Dr. Edward Darell, Harvard Pilgrim agreed to provide coverage for that second stay. Pet. App. 3a, 25a-26a.

B. Proceedings Below

On March 5, 2015, Doe sued under ERISA, 29 U.S.C. § 1132(a)(1)(B), challenging Harvard Pilgrim's denial of coverage for her residential treatment at Riggs from February 13 to June 18, 2013.

After Doe filed her complaint, Doe proposed and Harvard Pilgrim agreed to conduct another administrative review of Doe's claim. Pet. App. 32a. Dr. Joel Rubenstein, Harvard Pilgrim's Medical Director and a trained psychiatrist, reviewed the medical records from Doe's first admission, UBH's records, and Harvard Pilgrim's records and clinical discussions with Dr. Krikorian. *Id.* Dr. Rubenstein also considered the report by Dr. Darell on which Harvard Pilgrim had relied in granting coverage for Doe's second stay at Riggs. Dr. Rubenstein agreed with the previous assessments that, as of February 13, 2013, Doe could have safely stepped

down to a lower level of care. Pet. App. 32a. In response, Doe submitted the medical opinions of Dr. Gregory Harris, an independent medical reviewer she retained, and Dr. Eric Plakun, Riggs's Director of Admissions and Associate Medical Director. *Id.* On February 26, 2016, Harvard Pilgrim affirmed the denial of Doe's claim. Pet. App. 32a-33a.

Litigation of Doe's ERISA suit resumed, and the parties filed cross-motions for summary judgment. Doe did not seek an evidentiary hearing, witness testimony, or bench trial. The district court ruled in Harvard Pilgrim's favor, finding on de novo review that Doe's residential treatment at Riggs from February 13, 2013 to June 18, 2013 was not medically necessary. Dist. Ct. Dkt. 70. The court recognized that Doe's "mental ailments required ongoing treatment of some kind," but, applying the guidelines, concluded that Doe could have been safely transitioned to a partial-hospitalization program. *Id.* at 27. In reaching that decision, the district court confined its review to the administrative record as it existed as of March 12, 2013—the date OPP denied Doe's last appeal, *supra* p. 7—and did not consider any records from Doe's second stay at Riggs or documents from the further review Harvard Pilgrim conducted after Doe sued.

On her first appeal, Doe argued that the district court should have considered the additional materials Harvard Pilgrim considered during its post-lawsuit review. 17-2078 Appellant Br. 40-56 (1st Cir.). Doe did not argue that the court should have conducted an evidentiary hearing, taken live testimony, or held a Rule 52 bench trial. *Id.* at 27-56. To the contrary, Doe urged the court of appeals to resolve the merits of her claim on the paper record, arguing that in a de novo denial-of-benefits case, the court of appeals—like the district

court—could review the record itself to "weigh competing facts, resolve conflicting evidence, and draw reasonable inferences from the evidence." *Id.* at 26-27.

The court of appeals reversed in part, agreeing with Doe that the district court should have expanded the administrative record to include the materials Harvard Pilgrim considered during the post-lawsuit review—including the records and evaluations from Doe's second stay at Riggs and the additional medical opinions Doe submitted during the post-lawsuit review. *Doe* v. *Harvard Pilgrim Health Care, Inc.*, 904 F.3d 1 (1st Cir. 2018) ("*Doe I*"). Granting Doe precisely the relief she requested regarding the scope of the record, the court of appeals directed the district court to consider "all of Doe's medical records from both admissions to Riggs, as well as the reports of Dr. Darrell [sic], Dr. Harris, Dr. Plakun, and Dr. Krikorian." *Id.* at 9. The court of appeals declined to reach the merits, however, instead remanding and holding that the district court's merits decision would be subject to review on appeal for clear error. *Id.* at 9-11.

On remand, Doe for the first time requested an evidentiary hearing. Dist. Ct. Dkts. 99, 100.[2] She argued that, in light of the court of appeals' adoption of the clear-error standard, the district court had to make an independent determination of the facts in the record and that the court would "benefit" in doing so from live testimony. Dist. Ct. Dkt. 100 at 1, 8, 11. Doe made clear she was "not advocating for an evidentiary hear-

[2] Doe requested the hearing only in the course of seeking reconsideration of the denial of her earlier motion to add the file from the OPP review to the administrative record. Dist. Ct. Dkts. 99, 100. The district court denied reconsideration, Dist. Ct. Dkt. 118, and Doe did not pursue any further relief in regard to the OPP file.

ing in every de novo review ERISA case" and conceded that "[t]here may be many cases where district courts are able to make findings of facts" based on the paper record "or are able to evaluate the credibility of reviewing physicians reflected in their written reports without hearing testimony." *Id.* at 9. Doe did not suggest that she intended to challenge the credibility of any expert, and she emphasized that the hearing would "not be a vehicle for introducing new evidence." *Id.* at 12. A hearing, she said, would simply assist the court in better understanding the basis of each expert's opinion and "determining the weight to be given to each report." *Id.* at 10-12.

Doe did not argue that her request for a hearing made summary judgment inappropriate. Dist. Ct. Dkt. 100 at 9-12. To the contrary, Doe renewed her motion for summary judgment and agreed that the case should be resolved on cross-motions for summary judgment. Pet. App. 16a-17a; *see* C.A.J.A. 111 (joint scheduling order); C.A.J.A. 24, 29 (11/16/18 Hrg. Tr.). Moreover, in opposing Harvard Pilgrim's motion, Doe did not argue that any factual disputes precluded summary judgment. Dist. Ct. Dkt. 121 at 1-11.

The district court denied Doe's motion for an evidentiary hearing, Dist. Ct. Dkt. 118, and again granted summary judgment to Harvard Pilgrim. The court considered the expanded administrative record as the court of appeals had instructed, including all of Doe's proffered medical opinions, but concluded that Doe's continued residential treatment at Riggs from February 13 to June 18, 2013 was not medically necessary. Pet. App. 35a-47a.

The court based that determination largely on its extensive review of Doe's medical records from Riggs.

Examining whether Doe's symptoms could have been safely managed in a less restrictive setting, the court cited records showing that on multiple occasions at Riggs, Doe alerted staff during normal working hours to her need for additional monitoring and support—indicating to the court that, in a partial-hospitalization program, Doe "could have accessed nursing staff during the day to develop a plan for safely managing her symptoms should they escalate or become more pronounced at night." Pet. App. 37a-38a. The court also relied on records showing that Doe frequently left Riggs's campus in the evenings, spent several nights off campus to visit family and friends, and engaged in social activities away from Riggs. Pet. App. 39a. The court further noted instances documented in the medical records when the rigid structure at Riggs "seemed to have a negative impact" on Doe's mood and behavior. *Id.* The "totality of the record" therefore showed that Doe's symptoms "could have been safely managed in less restrictive treatment." *Id.* As to whether any imminent risk of psychosocial stressors would have undermined Doe's transition to a lower level of care, the court concluded that the medical records showed that Doe's symptoms had diminished by early February 2013. Pet. App. 40a-41a. By that point, Doe was not suicidal or psychotic, did not appear to be engaging in self-destructive behavior, displayed the ability to live autonomously, and was responding well to medication. *Id.*

The district court also considered the medical opinions on which Doe relied but concluded that they did not establish that Doe's continued stay at Riggs was medically necessary. Pet. App. 42a-47a. As to Dr. Krikorian, Doe's treating psychologist at Riggs, the district court "credit[ed]" her assessment of Doe's condi-

tion but explained that her letter could not support a finding of medical necessity because it did not speak to the dispositive issue under the UBH guidelines—*i.e.*, it "d[id] not suggest that [Doe's] symptomology could not be safely managed in less restrictive setting, for one example, a partial hospitalization program." Pet. App. 44a. Dr. Krikorian's letter explained "why hospitalization in an acute setting would not serve [Doe's] long-term interest in managing her symptoms" but "d[id] not appear to bear upon whether [Doe] could have been stepped down to a lower level of care without compromising her safety" during the relevant period. *Id.*[3]

Doe had also relied on the opinion of Dr. Darell, who determined that Doe's second admission at Riggs was medically necessary. But as the district court noted, Dr. Darell focused solely on that second admission, for which Harvard Pilgrim had allowed coverage. Pet. App. 46a. Dr. Darell "did not consider whether [Doe] should have received coverage for residential treatment" for the earlier period that was at issue in Doe's lawsuit. *Id.*

Finally, the court found unpersuasive the two opinions Doe submitted during Harvard Pilgrim's post-lawsuit review. As to Dr. Harris, the doctor retained by Doe's counsel to conduct an independent medical review, the court noted that "Dr. Harris did not examine [Doe] at any time relevant to this litigation," and that his "letter d[id] not provide new information regarding the medical necessity of [Doe's] residential treatment."

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[3] The court also noted that Dr. Krikorian's contemporaneous notes recorded that Doe had "difficulties with the structural restrictions of residential treatment," Pet. App. 44a, and that Dr. Krikorian had provided no explanation for her decisions regarding Doe's medication, Pet. App. 45a.

Pet. App. 46a. And Dr. Plakun, Riggs's Associate Medical Director of Admissions, opined only that Riggs "'meets the standard of care' for residential psychiatric treatment." Pet. App. 47a. The district court assumed that assessment was correct but concluded that it did not establish whether Doe's continued treatment at Riggs was medically necessary. *Id.*

Doe appealed again. She argued that the district court's determination on medical necessity was clearly erroneous because the court misunderstood Doe's symptoms and the appropriate treatment for mental illness and misapplied UBH's guidelines; that the court's factual determinations were clearly erroneous; and that the court erred in disagreeing with the opinions of her experts. 19-1879 Appellant Br. 30-57 (1st Cir.). Doe did not contend that the district court erred in resolving her case on motions for summary judgment or applied an improper summary-judgment standard. *Id.* And she did not contend that the court failed to consider any evidence outside the administrative record. *Id.*

Instead, Doe argued that the district court erred in denying her motion for an evidentiary hearing. 19-1879 Appellant Br. 21. According to Doe, the court of appeals' decision adopting the clear-error standard meant that the district court was obligated to "resolve" any "factual disputes … within the administrative record," "make factual determinations," and "draw inferences from those facts" to decide her claim. *Id.* at 27. Observing that the court of appeals had "left open the mechanism by which district courts are to implement this new standard," Doe urged the court of appeals to "permit" district courts to resolve de novo denial-of-benefits claims through a Rule 52 bench trial. Although she had requested a hearing with live testimony, she

argued that such bench trials should "presumptively [be] on the paper record," *id.* at 27-28—stressing that she was "not advocating that an evidentiary hearing is required in every de novo ERISA case" but simply suggesting that "[a]llowing district courts the option to hold an evidentiary hearing" where facts are in dispute "may assist in their decision-making process," *id.* at 29-30. Doe further emphasized that such an approach would "not necessitate expansion of the administrative record" beyond what was before the plan administrator. *Id.* at 27-28.

The court of appeals affirmed summary judgment for Harvard Pilgrim, concluding that the district court had properly "reviewed the record as a whole, drawing inferences from both the facts and the expert opinions," and that there was "no clear error" in its decision. Pet. App. 7a-9a. In regard to Doe's procedural arguments, the court of appeals noted that the district court had allowed the parties to submit "extensive written argument[s]" and heard oral argument and had properly considered "everything compiled by or submitted to Harvard Pilgrim in the course of making its final coverage decision," just as the court of appeals had previously instructed it to do. Pet. App. 9a-10a.

"In so proceeding," the court of appeals concluded, "the district court did exactly what the law called for." Pet. App. 10a. The court of appeals explained that it "presume[s]—absent some very good reason to do otherwise—that the record is limited to the record compiled by and submitted to the administrative decisionmaker leading up to and including its final administrative decision," and that Doe had cited "no good reason for why the district court should not have proceeded in accord with this strong presumption against supplementing the administrative record." *Id.* To the con-

trary, Doe did not claim that any materials were "improperly omitted from the record" or that the district court failed to comply with the court of appeals' prior decision "defining the record to be reviewed." *Id.* Instead, Doe "simply argue[d] that she would have preferred that the various experts testify and be subject to cross-examination"—an argument the court of appeals had "long ago rejected." *Id.* (citing *Orndorf* v. *Paul Revere Life Ins. Co.*, 404 F.3d 510, 518-519 (1st Cir. 2005)). "To the extent" Doe meant to argue that the district court should have conducted a Rule 52 bench trial without witnesses, the court noted that Doe never requested a Rule 52 bench trial and never explained how a bench trial on the papers would have differed from the de novo review the district court conducted on summary judgment. Pet. App. 9a n.2. Rather, in an ERISA case, the court held that "summary judgment … is akin to judgment following a bench trial in the typical civil case" and was a "proper vehicle for teeing up the case for decision on the administrative record." Pet. App. 4a-5a (quotation marks omitted).

REASONS FOR DENYING THE PETITION

I. THE FIRST QUESTION DOES NOT WARRANT REVIEW

Doe first asks this Court to grant review to consider whether Harvard Pilgrim's motion for summary judgment should have been denied due to factual disputes, contending that courts are divided as to whether such disputes may be resolved on summary judgment in a de novo denial-of-benefits case. But below, Doe agreed that summary judgment was the correct vehicle for deciding her claim; the argument she makes now is waived. Moreover, even if it were preserved, the issue would not warrant review. Although courts in some circuits set aside Rule 56 and allow de novo benefits

claims to be fully resolved at summary judgment, while others (mindful of Rule 56) prescribe doing so only after a bench trial or other proceeding not called summary judgment, the distinction has no practical impact. In practice, ERISA de novo denial-of-benefits cases are subject to the same independent review by district courts in all the circuits, regardless of the label used to identify the adjudication. The result in this case would certainly have been the same under any circuit's law.

A. Doe Waived The Argument That This Case Could Not Be Decided At Summary Judgment

In the courts below, Doe never made the argument she now advances (Pet. 18) that genuine issues of material fact precluded entry of summary judgment for Harvard Pilgrim. To the contrary, Doe sought summary judgment herself while acknowledging repeatedly that summary judgment was the appropriate vehicle for the district court to adjudicate her claim. Her argument here is therefore waived or at least forfeited. *See Hamer* v. *Neighborhood Hous. Servs. of Chi.*, 138 S. Ct. 13, 17 n.1 (2017).

As explained, the district court resolved this case on cross-motions for summary judgment. After Doe prevailed in her first appeal, which expanded the administrative record to the full extent Doe requested, she renewed her motion for summary judgment, as did Harvard Pilgrim. Pet. App. 17a. In a joint scheduling order, and again at a status hearing, Doe agreed that the case should be resolved on cross-motions for summary judgment. C.A.J.A. 24, 29, 111. And in opposing Harvard Pilgrim's motion for summary judgment, Doe did not argue that Rule 56 precluded summary judgment for Harvard Pilgrim due to a genuine factual dis-

pute; she simply argued the merits of the claim. *See* Dist. Ct. Dkt. 121 at 1-11.

Critically, Doe acceded to having the case adjudicated on motions for summary judgment even while recognizing that this would entail the district court "making credibility determinations, weighing the evidence, and making independent findings of fact." Dist. Ct. Dkt. 100 at 8; *see* 19-1879 Appellant Br. 27. In the court of appeals, Doe agreed that summary judgment was a proper vehicle "for teeing up the case" for precisely that kind of determination. 19-1879 Reply Br. 17. Indeed, in Doe's first appeal, Doe argued that the court of appeals should adjudicate her claim on the merits based on the paper administrative record, arguing that in a de novo denial-of-benefits case, the court of appeals "may, as did the District Court, weigh competing facts, resolve conflicting evidence, and draw reasonable inferences from the evidence" to determine whether Doe met her burden of proving that her stay at Riggs was medically necessary. 17-2078 Appellant Br. 26-27; *see id.* at 27 ("In ERISA cases, summary judgment is simply a vehicle for deciding the issues." (quotation marks omitted)).

That Doe later moved for an evidentiary hearing does not cure the waiver. Doe did not seek a hearing in lieu of summary judgment; she sought to stay the summary-judgment briefing pending completion of the hearing so the district court could "benefit from hearing live testimony" in deciding the motions and facilitate the court of appeals' clear-error review. Dist. Ct. Dkt. 100 at 11-12. Moreover, Doe disclaimed any argument that a hearing should be mandatory. *See id.* at 9; 19-1879 Appellant Br. 29. She acknowledged that "[t]here may be many cases where district courts are able to make findings of facts from the documents in

the Record or are able to evaluate the credibility of reviewing physicians reflected in their written reports without hearing testimony," Dist. Ct. Dkt. 100 at 9, while arguing simply that the court of appeals should "[a]llow district courts the option" to hold a hearing where doing so would "assist in their decision-making process," 19-1879 Appellant Br. 30. That is far from arguing that summary judgment had to be denied under Rule 56 due to factual disputes.

In her appellate reply brief, Doe clarified that she deliberately "termed her motion as one requesting an evidentiary hearing" rather than a request for a "Rule 52" proceeding "[b]ecause she was requesting a bench trial with witnesses"—a choice she downplayed as an "imprecise use of terminology." 19-1879 Reply Br. 23. For the reasons just discussed, Doe's argument would be waived regardless of how she termed her request for a hearing because she embraced summary judgment as the correct vehicle for resolving her claim. But even if that were not so, Doe should be held to her choice of terminology. The premise of Doe's first question presented is that the district court should be made to revisit the issue it already decided in a new proceeding labeled something other than "summary judgment." But Doe made a considered choice not to challenge the label the district court applied to its adjudication. She should not be heard to quibble with the nomenclature for the first time in this Court.

B. Differences In How The Circuits Label The Procedures For Resolving Benefits Claims Are Overstated And Unimportant

Courts agree that ERISA plaintiffs generally have no right to a jury trial, *e.g.*, *Patton* v. *MFS/Sun Life Financial Distributors, Inc.*, 480 F.3d 478, 484 (7th Cir.

2007), so the sole decision-maker who will review a plan's coverage determination is the district judge. Where a plan does not give the plan administrator discretionary authority to construe plan terms or determine eligibility for benefits, the district judge reviews a denial of benefits "under a *de novo* standard." *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 115 (1989); *see also Metropolitan Life Ins. Co.* v. *Glenn*, 554 U.S. 105, 111 (2008). As Doe acknowledged below, on de novo review, the district judge must weigh the evidence, resolve any factual disputes, and make an independent determination of the claimant's entitlement to benefits under the terms of the plan. That is precisely what the district court here did.

Doe's focus on the nomenclature applied to proceedings in which district courts conduct that review elevates form over substance. Regardless of whether ERISA de novo benefits claims are nominally decided at summary judgment under a standard that departs from Rule 56 by permitting courts to weigh the evidence and resolve any factual disputes at that stage (as in the First Circuit), or in a judgment issued after a bench trial or other proceeding (as in some other circuits), the review that a claimant is ultimately afforded does not materially differ. As the court of appeals explained below, a district judge's decision at summary judgment under the First Circuit's approach is "akin to judgment following a bench trial in the typical civil case." Pet. App. 5a (quotation marks omitted).

Doe relies heavily on the Seventh Circuit's decision in *Patton*, but that case confirms the practical insignificance of the distinction Doe highlights. The dispute there was whether the plan's denial of benefits should have been reviewed deferentially or de novo—and, if the latter, whether the district court should have

granted the claimant's motion for discovery. 480 F.3d at 483. In passing on those questions, the court of appeals noted its view, contrary to the First Circuit's, that the "normal" Rule 56 standard should govern motions for summary judgment in ERISA cases. *Id.* at 484 n.3. But the court also made clear that its disagreement with the First Circuit on that point was in most cases a distinction without a difference: what matters in de novo cases is whether the district court independently reviewed the entire record as the de novo standard requires. If the district court did so, then remand in most cases "would be an unwarranted empty formality," even if the district court granted summary judgment despite the existence of genuine issues of material fact. *Id.* at 484 (quotation marks and footnote omitted). That is because a district court that already granted summary judgment to one party after independently considering the whole record, "if required to conduct a bench trial on that same record, will probably decide the case for that same party"—making it "pointless to correct any error in the grant of summary judgment." *Id.*

In contrast, the error that the Seventh Circuit identified in *Krolnik* v. *Prudential Insurance Company of America*, 570 F.3d 841 (7th Cir. 2009), on which Doe also relies, was not that the district court conducted an independent review at the summary judgment stage, but that the district court failed to conduct the required independent review at all. *Id.* at 844 (district court failed to "weigh *all* of the medical evidence" or even "mention any of the evidence favoring [the claimant]"). Here, the district court did weigh all of the evidence and conducted a thorough independent review. Doe's complaint in this Court is that the district court should not have done so in a proceeding called "sum-

mary judgment"—a distinction the Seventh Circuit agrees is "pointless" to enforce in most cases. *Patton*, 480 F.3d at 484.[4]

None of the other decisions Doe cites from other circuits suggests that the district court's ultimate role in evaluating de novo denial-of-benefits claims in those circuits differs in substance from the approach taken in the First Circuit. Indeed, most of the cases are readily distinguishable. In *O'Hara* v. *National Union Fire Insurance Company of Pittsburgh, PA*, 642 F.3d 110 (2d Cir. 2011), for example, the Second Circuit reversed the grant of summary judgment to the plan because the district court "essentially appl[ied] deferential rather than de novo review," contrary to *Firestone*. *Id.* at 117. The Tenth Circuit had the same concern in *Niles* v. *American Airlines, Inc.*, 269 F. App'x 827, 834 (10th Cir. 2008) (unpublished), where the district court reviewed only one doctor's report to determine whether there was "substantial evidence for the [insurer's] decision," when it "should instead have examined all the medical evidence." Similarly, in *Kirwan* v. *Marriott Corp.*, 10 F.3d 784, 788-789 (11th Cir. 1994), the district court erred by applying deferential instead of de novo

[4] In dicta, *Krolnik* also suggested that a de novo denial-of-benefits suit should not be conceived of as a "'review'" of the plan's benefits determination at all, but should be litigated from scratch like a breach-of-contract dispute. 570 F.3d at 843. *But see Orndorf* v. *Paul Revere Life Ins. Co.*, 404 F.3d 510, 519 (1st Cir. 2005) ("The decision to which judicial review is addressed is the final ERISA administrative decision."). Doe's petition does not ask this Court to answer that question, Pet. I, and for good reason: Doe has consistently litigated this case on the premise that her claim called for de novo review of Harvard Pilgrim's determination on the administrative record. That is why her first appeal focused on defining what materials the administrative record comprised. *Supra* pp. 8-9.

review. And in *Phelps* v. *C.T. Enterprises, Inc.*, 394 F.3d 213 (4th Cir. 2005), the Fourth Circuit expressly declined to wade into any debate over the proper stage at which to render final judgment on a claim such as Doe's. *Id.* at 218. The court explained that questions of whether to "import[] the summary judgment standard whole-cloth into the ERISA context … arise chiefly when courts are reviewing claims for benefits under 29 U.S.C. § 1132(a)(1)(B)," but the plaintiffs "press[ed] no such claims [t]here." *Id.*[5]

Thus, although Doe is generally correct that several courts, unlike the First Circuit, take the view in light of Rule 56 that de novo denial-of-benefits claims should be adjudicated in a proceeding labeled something other than "summary judgment" where there are disputed material facts, none of the cases Doe cites suggests that the circuits' approaches differ in substance. The only case she cites that suggests there might be a meaningful difference between resolving a denial-of-benefits claim at summary judgment rather than after a bench trial, *Kearney* v. *Standard Insurance Co.*, 175 F.3d 1084, 1094 (9th Cir. 1999) (en banc), in fact confirms the opposite. There, rather than focusing on procedural distinctions, the Ninth Circuit reversed the grant of summary judgment in favor of conducting a bench trial because the district court had focused only on "whether there is a genuine issue of material fact," rather than

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[5] Several of the other cases Doe cites were not de novo cases. *See, e.g.*, *Reed* v. *CITIGROUP, Inc.*, 658 F. App'x 112, 113 (3d Cir. 2016) (per curiam) (unpublished); *Rhorer* v. *Raytheon Eng'rs & Constructors, Inc.*, 181 F.3d 634, 639 (5th Cir. 1999) (dispute concerned interpretation of policy terms), *abrogated on other grounds by CIGNA Corp.* v. *Amara*, 563 U.S. 421 (2011); *Silva* v. *Metropolitan Life Ins. Co.*, 762 F.3d 711, 718 (8th Cir. 2014) (dispute concerned interpretation of plan terms).

asking the decisive question whether the plaintiff actually "[wa]s disabled within the terms of the policy." *Id.* at 1095. That concern is not present under the First Circuit's approach. As Doe acknowledges (Pet. 17), a district court considering a motion for summary judgment in the First Circuit does not ask whether there is a genuine issue of material fact; it asks whether the ERISA claimant met his or her burden to prove entitlement to benefits under the plan—*i.e.*, exactly the inquiry the Ninth Circuit directed the district court to conduct (albeit under a different procedural label).

Nor does Doe cite any reason why the courts of appeals' distinct approaches would make a difference to the outcomes of denial-of-benefits cases. For example, nothing prevents a court adjudicating a claim upon a bench trial under the other circuits' approach from doing so entirely on the papers, without an evidentiary hearing. Indeed, Doe argued below that a bench trial in a de novo denial-of-benefits case should "presumptively" be on the papers. *Supra* pp. 13-14. And as the court of appeals noted, Doe has never explained how the "bench trial on the papers" conducted in other circuits would differ at all from the "de novo review the district court conducted" in this case at summary judgment. Pet. App. 9a n.2.

Instead, Doe falls back on the second question presented, suggesting that the "difference between summary judgment and a bench trial implicates … whether district courts can consider additional evidence" outside of the administrative record. Pet. 17. But the First Circuit's endorsement of summary judgment as the "'vehicle for deciding the [benefits] issue'" applies in cases where the record before the court is "'the same record that was before the plan administrator.'" *Scibelli* v. *Prudential Ins. Co. of Am.*, 666 F.3d 32, 40 (1st

Cir. 2012); *see also Doe* v. *Harvard Pilgrim Health Care, Inc.*, 904 F.3d 1, 10 (1st Cir. 2018) ("*Doe I*"); *Orndorf* v. *Paul Revere Life Ins. Co.*, 404 F.3d 510, 518 (1st Cir. 2005) (summary judgment without trial is appropriate "[w]here review is properly confined to the administrative record before the ERISA plan administrator"). Where district courts exercise discretion to consider evidence outside the administrative record—which, as explained below, the First Circuit agrees is permissible—summary judgment might or might not be appropriate. The court of appeals had no occasion to consider that question because Doe did not argue that the district court erred by omitting any evidence from the record. Pet. App. 10a.

C. Further Review Would Not Change The Result

The facts of this case illustrate why the distinctions in the courts of appeals' nomenclature for de novo denial-of-benefits cases make no meaningful difference. The result in this case would have been the same had it arisen in any other circuit. The district court could have denied summary judgment and conducted a bench trial on the papers, engaging in the exact same review of Doe's medical records and the expert opinions and reaching the exact same conclusion. As the Seventh Circuit has held, remanding for the district court to do so would be an "empty formality." *Patton*, 480 F.3d at 484.

As an initial matter, it is far from clear that Doe's claim would have survived summary judgment even if the First Circuit applied the traditional Rule 56 analysis. Whether Doe was entitled to benefits depended on whether residential treatment was "medically necessary" as defined in UBH's guidelines. Pet. App. 38a-39a. As the district court explained, the medical opin-

ions on which Doe says a bench trial would have focused did not speak to that question. Pet. App. 43a-47a; *see supra* pp. 11-12. Dr. Krikorian's assessment did "not suggest that [Doe's] symptomology could not be safely managed in less restrictive setting"; Dr. Darell did not analyze the relevant time period; Dr. Harris only reviewed treatment records after the fact and did "not provide new information regarding" medical necessity; and Dr. Plakun assessed only whether Riggs met the standard of care for residential treatment. *Id.*

But even assuming summary judgment would have been denied under a traditional Rule 56 analysis, the ensuing adjudication would have been no different from what occurred. Doe's case would have proceeded to a bench trial before the same judge, who would have weighed the same evidence under the same "medical necessity" definition. The judge would have "treated as comprising the record everything compiled by or submitted to Harvard Pilgrim in the course of making its final coverage decision," "allowed the parties to submit extensive written argument directed to that record," and "held oral argument and issued a decision"—*i.e.*, exactly what already occurred. Pet. App. 9a-10a. As Doe has conceded, it would have been well within the court's discretion to decline to hear live testimony and base its decision on the paper record. *Supra* p. 13.

Doe suggests that at a hearing, the district court could have made "credibility determinations" concerning the medical experts. But she does not attack the credibility of any of the experts, and neither did the district court. Indeed, the court's decision did not even rely on the Harvard Pilgrim experts' analysis but instead rested primarily on the contemporaneous medical records of Doe's stay at Riggs. *Supra* pp. 10-12. And in considering the expert opinions Doe proffered, the

court did not discredit their views but simply found that they did not speak to the "medical necessity" standard. *Supra* pp. 11-13. Doe also suggests that, following a bench trial, the district court would have been required to "'find[] the facts "specially," as [Rule 52] requires.'" Pet. 17 (quoting *Kearney*, 175 F.3d at 1095). But even if Doe had asked the district court to enter findings pursuant to Rule 52—which she did not—Doe does not identify any respect in which the district court's detailed and thorough opinion fell short of that mark or would differ after remand.

II. THE SECOND QUESTION DOES NOT WARRANT REVIEW

Doe likewise attempts to harness her case to an alleged circuit split regarding district courts' discretion to consider evidence outside the administrative record. But the circuit courts are generally in accord on this issue, and even if Doe could show a division, this case would be a poor vehicle for resolving it.

A. There Is No Deep Or Important Circuit Split Regarding Extra-Record Evidence

Although the courts of appeals have sometimes phrased the point in different terms, the vast majority—including the First Circuit—have coalesced around the principle that district courts have discretion to determine, on a case-by-case basis, whether to admit new evidence in de novo denial-of-benefits cases.

1. Citing *Orndorf*, 404 F.3d 510, Doe argues that in the First Circuit, "unless the plaintiff has challenged the procedures used by the plan administer, district courts must confine themselves to the record before the administrator." Pet. 19. Doe misreads *Orndorf*. The question there was narrow: whether evidence of the plaintiff's condition collected after an insurer's final de-

cision was admissible. Affirming the district court, the First Circuit held that the final administrative decision "acts as a temporal cut off point." 404 F.3d at 519.

Contrary to Doe's characterization, the First Circuit did not set forth a categorical rule regarding the scope of the record. It acknowledged that new evidence "is more obviously relevant when the attack is on the process of decision making." *Orndorf*, 404 F.3d at 520. But it declined to "catalogue the situations in which new evidence is admissible," suggesting that external evidence could be admitted for other reasons as well, such as to "explain a key item." *Id.* The First Circuit also noted that although other circuits have elaborated on the measures for evaluating admissibility of "such extra-administrative record evidence," it was not "decid[ing] the issue." *Id.*

Orndorf thus did not adopt the "rigid" approach Doe ascribes to it. Pet. 20. Indeed, the First Circuit has since reiterated that "the record in an ERISA benefit-denial case may be expanded for 'good reason.'" *Stephanie C.* v. *Blue Cross Blue Shield of Mass. HMO Blue, Inc.*, 852 F.3d 105, 110 n.1 (1st Cir. 2017). Similarly, the decision below observed merely that courts "presume—absent some very good reason to do otherwise—that the record is limited to the record compiled by and submitted to the administrative decisionmaker." Pet. App. 10a. As Doe conceded below, the First Circuit's approach is thus "consistent with" that of other circuits that "le[ave] in the hands of the district courts … whether to admit new evidence." 19-1879 Appellant Br. 28 n.10.

2. Accurately stated, the First Circuit's position—that the record is generally limited to the evidence before the administrator but may be expanded at

the district court's discretion for good reason—accords with the approach taken by most other circuits.

The Second Circuit, like the First, has stated that review in de novo cases "is limited to the record in front of the claims administrator unless the district court finds good cause to consider additional evidence." *DeFelice* v. *American Int'l Life Assurance Co. of N.Y.*, 112 F.3d 61, 66 (2d Cir. 1997). Although *DeFelice* explained that the district court "should not limit its consideration to matters previously appraised in the administrative proceedings," *id.* at 67, it did so because in that case a "blatant conflict exist[ed] at the administrative level," *id.* at 66—which was "an example of 'good cause,'" *id.* at 67. This approach aligns with *Orndorf*, which stated that "personal bias" by the plan administrator may warrant supplementing the administrative record. 404 F.3d at 520.

The Third Circuit's decision in *Luby* v. *Teamsters Health Welfare, & Pension Trust Funds*, 944 F.2d 1176 (3d Cir. 1991), on which Doe heavily relies, likewise aligns with that approach. The court there held that "a district court exercising *de novo* review over an ERISA determination between beneficiary claimants is not limited to the evidence before the Fund's Administrator," but it also explained that this did not mean the district court should "conduct a *de novo* evidentiary hearing or full trial *de novo*." *Id.* at 1184-1185; *see also Viera* v. *Life Ins. Co. of N. Am.*, 642 F.3d 407, 418 (3d Cir. 2011). Considering extra-record evidence was appropriate in that case because otherwise "[t]here was simply no evidentiary record for the district court to review" on a critical issue in the case. *Luby*, 944 F.2d at 1185.

Most other circuits agree that district courts should ordinarily limit their review to the record before the plan administrator but have some discretion to consider additional evidence. *See Quesinberry* v. *Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1026-1027 (4th Cir. 1993) (district courts "should review only the evidentiary record that was presented to the plan administrator," except where the court concludes "additional evidence is necessary for resolution of the benefit claim"); *Ariana M.* v. *Humana Health Plan of Tex., Inc.*, 884 F.3d 246, 256 (5th Cir. 2018) (en banc) (district courts must remain within the "bounds" of the administrative record, but may exercise discretion to consider extrinsic evidence "in very limited circumstances," including where necessary to explain prior application of plan terms or medical terminology); *Donatelli* v. *Home Ins. Co.*, 992 F.2d 763, 765 (8th Cir. 1993) (district courts may permit additional evidence "[i]f it is necessary for adequate de novo review," but "should not exercise this discretion absent good cause to do so"); *Sloan* v. *Hartford Life & Accident Ins. Co.*, 475 F.3d 999, 1004 (8th Cir. 2007) ("good cause" inquiry focuses on whether claimant had an opportunity to present evidence to the administrator); *Mongeluzo* v. *Baxter Travenol Long Term Disability Benefit Plan*, 46 F.3d 938, 944 (9th Cir. 1995) (in "most cases," district court should limit itself to evidence before the plan administrator but has discretion to allow new evidence "only when circumstances clearly establish that additional evidence is necessary to conduct an adequate de novo review"); *see also Kearney*, 175 F.3d at 1090-1091 (same); *Hall* v. *UNUM Life Ins. Co. of Am.*, 300 F.3d 1197, 1202 (10th Cir. 2002) (district courts should "ordinarily … restrict de novo review to the administrative record" and "strictly limit[]" consideration of additional evidence to cases "when circum-

stances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review").

3. Two circuits, the Seventh and Eleventh, have framed district courts' discretion to consider new evidence in relatively more expansive terms. But a closer look at those courts' decisions reveals little practical difference between their approach and the approach taken in other circuits.

Doe cites the Seventh Circuit's statement in *Dorris* v. *Unum Life Insurance Company of America*, 949 F.3d 297, 304 (7th Cir. 2020), that a district court should permit supplementation "freely," but the court also stated that a district court may "limit itself to deciding the case on the administrative record." And in the Seventh Circuit, as elsewhere, the "most important factor" for a district court deciding whether to allow extra-record evidence is whether the "evidence is necessary to an informed and independent judgment." *Patton*, 480 F.3d at 491 (quotation marks omitted).

As for the Eleventh Circuit, nearly three decades ago it stated that district courts can consider "facts not before the plan administrator"—a view the court believed diverged from the views of its sister circuits. *Kirwan*, 10 F.3d at 789 n.31. But as explained, virtually all circuits agree that district courts have discretion to consider new evidence.

Only the Sixth Circuit appears to have adopted the view that district courts may not consider evidence outside the administrative record. *See Perry* v. *Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990). But even that court subsequently recognized an exception allowing an insured to present new evidence that the plan administrator did not afford an adequate review

process. *See VanderKlok* v. *Provident Life & Accident Ins. Co.*, 956 F.2d 610, 617 (6th Cir. 1992).

The "intractable" circuit split Doe asserts thus does not withstand scrutiny. The courts of appeals largely agree that district courts should limit their review to the record before the plan administrator but may exercise discretion to consider additional evidence when doing so is necessary to conduct an independent de novo review.

B. This Case Is A Poor Vehicle

Even if there were a meaningful division among the circuits, this case would be a poor vehicle to resolve it. The issue is arguably waived; and even if it were preserved, the outcome would not change under any other circuit's approach.

Doe never sought to introduce new evidence outside the administrative record, other than live testimony of medical experts whose opinions were already in the record. *Supra* pp. 9-10. As explained, the focus of Doe's first appeal was the scope of the record to be considered. Doe argued that the district court should have considered all the materials submitted during Harvard Pilgrim's voluntary post-lawsuit review. The court of appeals granted that relief. *Supra* pp. 8-9. It was not until the remand from that first appeal—in the context of Doe's later-abandoned effort to add the OPP file to the administrative record, *supra* pp. 9-10 & n.2—that Doe for the first time sought an evidentiary hearing. But she did not seek to expand the record through that testimony. Instead, Doe affirmed that the hearing she sought would "*not* be a vehicle for introducing new evidence." Dist. Ct. Dkt. 100 at 12 (emphasis added). Thus, in the appeal below, Doe did not argue that any

material was "improperly omitted from the record" or that the district court erred in "defining the record to be reviewed." Pet. App. 10a.

Doe also never argued that the district court was obligated to hear the experts' live testimony or explained why it was necessary. She merely argued that doing so would "benefit" or "assist" the district court's weighing of the evidence and that courts should therefore have the "option" to hear such testimony even though it was not "required." *Supra* pp. 9-10, 13-14. Even under the most expansive interpretation of the district court's duty to perform de novo review, the court undoubtedly had discretion—under any circuit's law—to decline to receive the duplicative testimony Doe belatedly proposed. Indeed, the central purpose of Doe's request—to weigh the conflicting views of medical professionals—was impossible from the outset because the independent reviewer appointed by the Massachusetts OPP would not have been able to appear; OPP precludes disclosure of that physician's identity. *Supra* p. 6. The district court thus could not have heard from that witness. And absent that testimony, any evidentiary hearing would have been one-sided and incomplete.

Any district court considering whether to exercise its discretion to supplement the record would have to take these circumstances into account. Any one of those factors—the posture of the case, Doe's delay in seeking a hearing, the futility of holding a hearing at which a key witness could not appear, the risk of prejudice—could justify denying Doe's eleventh-hour request.

CONCLUSION

The petition should be denied.

Respectfully submitted.

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