NO. 24-1080

In the Supreme Court of the United States

ESTATE OF MICHAEL GIFFORD,
BY ITS SPECIAL ADMINISTRATOR,
SUZANNE GIFFORD,

Petitioner,

v.

OPERATING ENGINEERS LOCAL 139
HEALTH BENEFIT FUND,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the Seventh Circuit correctly determined that the Fund's decision to deny benefits was not arbitrary and capricious.

2. Whether the Seventh Circuit correctly determined that the lower court properly exercised its discretion in limiting discovery to the administrative record.

CORPORATE DISCLOSURE STATEMENT

The Respondent OPERATING ENGINEERS LOCAL 139 HEALTH BENEFIT FUND[1] is not a corporation. Rather, it is a self-funded multiemployer Taft-Hartley health plan. No public company owns 10% or more of the plan.

[1] Note: The Petitioner improperly identifies the Respondent as "Operating Engineers 139 Health Benefit Fund".

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INTRODUCTION

Petitioner urges this Court to discard more than five decades of well-settled precedent and upend the careful balance Congress struck in ERISA. Petitioner's request would open the floodgates to full-scale litigation in routine benefit denial cases, dragging district courts into the same morass of discovery disputes and burdensome procedures that ERISA was specifically designed to avoid. Such a sweeping change would transform a streamlined, administrative benefits-review scheme into a litigation-heavy battleground, contrary to the text, history, and purpose of the statute—and, notably, without any compelling reason to do so.

In support of its request, Petitioner attempts to manufacture a circuit split over the scope of discovery in ERISA benefit denial cases by conflating the nuanced, case-specific application of a well-settled rule with doctrinal disagreement. But lower courts consistently recognize that discovery in such cases is generally limited or disallowed, in line with the statute's purpose and this Court's precedent. Notably, Petitioner did not seek rehearing *en banc* under Federal Rule of Appellate Procedure 40(b)(2), as would be expected if a genuine circuit conflict existed. Nor does the Seventh Circuit's opinion suggest any such conflict, as required by Circuit Rule 40(e)—further confirming the panel saw no discord with other circuits. What Petitioner casts as a legal conflict is, in reality, the routine exercise of judicial discretion in applying the same rule to differing facts. Disagreement over case outcomes does not equate to a disagreement over legal standards. Petitioner's attempt to elevate

factual variation into a cert-worthy conflict only highlights the weakness of its case.

Despite the uniform application of a consistent legal standard limiting discovery across the circuits, Petitioner—unhappy with the outcome below—leans on a single remark from the Seventh Circuit, taking it out-of-context and inflating it into a so-called "dire" consequence of what it claims are "judicially-invented rules" precluding discovery. This characterization is both misleading and overstated. The Seventh Circuit did not invent a rule precluding discovery; rather, it applied the same well-established principles that other circuits have endorsed to ensure that discovery remains proportional and tethered to the requirements of the statute.

Petitioner's attempt to spin this unrelated issue into a circuit split is pure rhetorical sleight of hand. And contrary to the narrative implied in the Petition, Respondent is not a deep-pocketed insurance giant, but a self-funded multiemployer Taft-Hartley health plan established by a labor organization and local employers for the benefit of employees working in the construction industry. This Court should see Petitioner's argument for what it is: an appeal driven by dissatisfaction with the result, not by any genuine conflict in the law.

Finally, Petitioner's argument that the Plan failed to provide a full and fair review rests on a mischaracterization of ERISA's requirements and a misplaced reliance on *Garner v. Central States*, advancing the same argument that was rightfully rejected by the lower courts. The Seventh Circuit's decision aligns with other courts of appeals that have held claimants cannot invoke judicial review to remedy their own failure to

provide relevant evidence during the administrative process. Courts across all circuits have consistently rejected efforts to use litigation to fill evidentiary gaps left open by a claimant's own inaction. Nothing in the Seventh Circuit's decision is at odds with that settled understanding. It simply declined to rewrite the Plan's language or infer obligations that neither ERISA nor controlling precedent support. It correctly observed that while Congress could have mandated specific terms defining when services qualify as an "emergency," it chose not to—and the Plan itself contains no such requirement

COUNTERSTATEMENT OF THE CASE

I. Background

A. The Plan and Its Terms.

Respondent is a self-funded, multiemployer health plan established by the International Union of Operating Engineers Local 139 and its signatory employers to provide health benefits to eligible participants and their dependents (the "Plan"). (App.2a.) The Plan is administered by a Board of Trustees (of equal management and labor representation) with broad discretion to interpret Plan provisions and determine benefit eligibility. (App.57a.) The Plan's Summary Plan Description ("SPD") expressly grants the Trustees authority over interpretation of the Plan's terms and its governing documents, and final and binding authority over benefit decisions. (App.3a.)

At all relevant times, Michael Gifford was a participant in the Plan. (App.2a.) The Plan generally excludes out-of-network charges, subject to some exceptions, such as certain emergency services. (App.4a.) The Plan also imposes other conditions, including a requirement that services must be "Medically Necessary." (*Id.*) The SPD repeatedly emphasizes that participants must obtain care from PPO-network providers for services to be covered and that out-of-network care is only reimbursed in narrowly-defined, emergency circumstances. (App.4a.) To that end, the SPD instructs participants to "always check to see if [their] provider is in the network" while also acknowledging that confirming

in-network status may not be possible during an emergency. (*Id.*)

The SPD also contains instructions for appealing an adverse benefits decision. (App.5a.) It provides that a participant may appeal a denial of benefits in writing and must explain the reasons for disagreement. Importantly, the SPD contains the following instruction:

> [A participant] may provide any supporting documents or additional comments related to this review. When filing an appeal [the participant] may:
>
> Submit additional materials, including comments, statements, or documents; and
>
> Request to review all relevant information (free of charge).
>
> Records and documents [a participant] submit[s] on appeal will be considered without regard to whether such information was submitted or considered in the initial benefit determination.

(*Id.*)

The SPD provides an opportunity for the participant to appear before the Trustees to present any additional information, and states that, when a timely appeal is filed, "a new, full, and independent review of [the] claim will be made, and the decision will not be deferred to the initial benefit decision." (*Id.*) The SPD advises that, at that point, the Plan's Board of Trustees will make a final decision based on "all information used in the initial determination as well as any additional information submitted" during the appeal. (App.6a.)

B. Mr. Gifford's Hospitalization and Surgery.

On July 4, 2021, Mr. Gifford was admitted to Froedtert South hospital after experiencing a stroke.[1] (*Id.*) His symptoms resolved following administration of tissue plasminogen activator (tPA), and records reflect complete resolution of the stroke. (App.6a.) While under observation, a CT scan revealed a previously undiagnosed brain aneurysm described as "incidental" and as needing "occasional" monitoring. (App.6a.)

Two days later, Mr. Gifford consulted with Dr. Arvind Ahuja, an out-of-network neurosurgeon. (App.7a.) Following that consultation, Dr. Ahuja recommended, and Gifford consented to, surgical clipping of the aneurysm. (*Id.*) The surgery was performed on July 7—three days after Mr. Gifford's admission to the hospital. Post-operative assessment notes—which were a part of the administrative record—describe that the aneurysm was larger than it appeared on diagnostic workups and that there was evidence of prior bleeding.[2] (*Id.*) Mr. Gifford experienced post-

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[1] Petitioner misrepresents the factual record by asserting that physicians merely "believed" Mr. Gifford was suffering a stroke. (Pet. at 9.) This is inaccurate. The medical records—and Petitioner's own briefing—confirm that Mr. Gifford did, in fact, suffer a stroke. (App.6a n.2.) The Seventh Circuit expressly identified this factual discrepancy, noting that "[t]he Estate's counsel at oral argument represented that Gifford did not, in fact, suffer a stroke. However, this is belied by the medical records and the Estate's own brief, which states that 'Mr. Gifford had a stroke, and then was diagnosed with an aneurysm.'" (App.6a n.2.)

[2] In discussing Dr. Ahuja's alleged findings upon performing the surgery in question, Petitioner makes repeated factual misrepresentations to this Court. Petitioner first asserts that "[t]he original attending physicians simply missed the vasospasm."

operative complications and died eleven days later on July 18, 2021. (App.7a.)

C. The Claim and Administrative Appeal.

Dr. Ahuja's medical practice submitted a claim to the Fund for reimbursement for the services provided to Gifford, including the brain surgery. (App.7a.) The Fund denied the claim on grounds that the surgery was performed by an out-of-network provider and was not rendered in an emergency, nor was it medically necessary. (App.7a-8a.)

Suzanne Gifford, Mr. Gifford's wife, appealed, asserting only her belief that the surgery was emergent. (App.8a.) She submitted no additional documentation, did not request access to the claim file, and did not ask to appear before the Trustees—despite the SPD providing those rights. (*Id.*) The appeal consisted solely of a one-paragraph letter stating: "a stroke with a ruptured brain aneurysm is a clear emergency." (*Id.*) At no point did Mrs. Gifford attempt to submit any additional evidence during the administrative appeal, including, as relevant, the alleged "crucial surgical note" from Dr. Ahuja. (*See* Pet.11.)

(Pet.10, 24.) This has no support in the record. Similarly, Petitioner asserts that "[t]he presence of vasospasm confirmed that Dr. Ahuja's diagnosis was correct—i.e., that surgery was necessary, and that the surgery needed to be completed in an emergency timeframe." (*Id.*) This also has no support in the record. These are not facts; they are Dr. Ahuja's post hoc, self-serving opinions which were not presented to the Board of Trustees during the administrative appeal process, but instead offered for the first time in litigation. (App.10a.) Presenting them as established medical findings is not just inaccurate—it's misleading.

In response, the Fund engaged two independent medical review organizations. (App.8a.) Both assigned board-certified neurosurgeons to evaluate the claim—Dr. Jasmin and Dr. Kaloostian. (App.8a-9a.) After reviewing Gifford's medical records, both neurosurgeons concluded that the surgery was not performed in the event of an emergency. (*Id.*)

Specifically, Dr. Jasmin concluded that the surgical clipping of Gifford's aneurysm was not a medical emergency, even opining that performing surgery on the aneurysm so soon after the treatment of Gifford's stroke likely exposed him to "a higher risk of complication than if it had been postponed to a later date." (App.8a.) Similarly, Dr. Kaloostian concluded that the surgery was neither medically necessary nor performed in the event of an emergency. (App.9a.) He explained that the aneurysm was small, "completely incidental," and that there was "no emergency and no stroke" on the date of the surgical clipping. (*Id.*) Notably, Dr. Kaloostian also opined that the treating providers had time to contact insurance regarding in-network options. (*Id.*) Both independent medical reviewers certified that their compensation was not dependent upon the conclusions offered in their reports and that no conflicts of interest existed. (*Id.*)

The Fund's Appeals Committee—comprised of an equal number of management and labor trustees—considered Mrs. Gifford's appeal and the independent medical reviews, and unanimously upheld the denial. (*Id.*) The full Board of Trustees adopted the Committee's recommended decision. (*Id.*) Thereafter, the Fund notified Mrs. Gifford of the denial in writing, explaining that the claim was reviewed by two independent medical review organizations, and that both of them

concluded that Mr. Gifford's surgery was not performed in the event of an emergency. (*Id.*)

D. The Administrative Record.

The administrative record included all materials submitted, generated, or considered in the benefit determination process, including hospital records from July 4-19, 2021, which were transmitted to the Fund's medical reviewers. (App.21a, 23a.) Although Petitioner later alleged that a surgical note was omitted, the district court correctly found that the surgical note was entered 12 days after the surgery, and did not alter the substance of the medical conclusions. (App.36a.)

E. Procedural History.

Following the administrative denial of benefits, Suzanne Gifford, as Special Administrator of Robert Gifford's Estate, brought suit under ERISA §§ 502 (a)(1)(B) and (a)(3), alleging wrongful denial of benefits and seeking equitable relief for purported statutory violations. (App.10a.) After the Fund produced the administrative record, Gifford sought discovery outside that record, including depositions of Trustees. (App.10a, 28a.) In response, the Fund moved for a protective order. (App.10a.) While that motion was pending, both parties filed for summary judgment. (*Id.*)

In opposition to the Fund's motion for summary judgment, Petitioner submitted previously unsubmitted materials, including the alleged "missing" surgical note and declarations from Dr. Ahuja opining that vasospasm and pre-operative bleeding rendered the surgery emergent and medically necessary. (App.10a.) The "missing" records contained two reports prepared by Dr. Ahuja *after* he provided the surgical services.

(*Id.*) Dr. Ahuja's corresponding declarations attempted to clarify the surgical note and justify the necessity of Gifford's surgery. (App.10a-11a.) Dr. Ahuja stated that imaging before surgery revealed vasospasm caused by a small sentinel bleed—something he believed other physicians missed—which required urgent intervention. (App.11a.) Although Dr. Ahuja's surgical note primarily reflected intraoperative findings, Dr. Ahuja nonetheless asserted that any competent physician reviewing the surgical note would recognize the need for emergency surgery. (*Id.*) Although Dr. Ahuja claims to have entered the note into the hospital's electronic records, it was not completed and signed until July 19, 2021—twelve days *after* the operation and *after* Mr. Gifford's death. (*Id.*) While Gifford's medical records were faxed to the Fund, the surgical note wasn't included, likely because it wasn't finalized in time. (*Id.*) As a result, the Fund never received the note, and it wasn't part of the administrative record. (*Id.*) Although these materials were never provided to the Fund during the administrative process, Petitioner contended that their absence rendered the Fund's review procedurally inadequate. (App.35a-36a.)

The district court granted summary judgment for the Fund and entered a protective order. (App.12a.) It held that the Fund's decision was not arbitrary and capricious, that it conducted a full and fair review under ERISA, and that discovery outside the administrative record was not warranted. (*Id.*) The court also dismissed the Estate's ERISA § 502(a)(3) claim, concluding that the Fund's interpretation of the Plan was reasonable, and that no separate equitable relief was appropriate. (App.27a.) Gifford's motion for reconsideration or remand was denied, as the district

court found no procedural violations and no basis to order the Fund to consider materials outside the administrative record. (App.12a, 38a.)

The Seventh Circuit affirmed each of the lower court's rulings. It rejected the Estate's argument that the Fund was obligated to discover or incorporate "missing" records it did not know existed, emphasizing that claimants, not plan administrators, bear responsibility for supplying relevant evidence. (App.15a.) The court distinguished the Sixth Circuit's decision in *Garner v. Central States*—a case heavily relied upon by the Petitioner—noting that unlike *Garner*, the Fund never possessed the disputed surgical note, and no medical reviewer based their conclusion on its absence. (App.16a-20a.) The Seventh Circuit further upheld the district court's protective order, finding no structural conflict of interest in the Fund's administration and no basis for discovery beyond the administrative record. (App.31a.)

Despite the clear factual and legal findings of the lower courts, Petitioner now seeks a writ of certiorari from this Court, urging review of a routine denial-of-benefits claim that presents no conflict, misapplication of established law, or question of exceptional public importance.

REASONS FOR DENYING THE PETITION

The Petition should be denied for multiple, independent reasons:

First, and fundamentally, Petitioner's position is incompatible with ERISA's core purpose and would require this Court to overturn long-standing precedent governing the appropriate standard of judicial review of benefit determinations by plan administrators and fiduciaries. Congress enacted ERISA to protect benefits promised to plan participants under the terms of a plan's governing documents while also encouraging employers to establish, form, and administer employee benefit plans. To that end, federal courts have developed common law respecting the discretionary authority of plan fiduciaries, which limits judicial review of the contractually defined administrative process. The expansive discovery regime Petitioner proposes would overturn this entire body of established precedent, exposing plan administrators, employers, and service providers to litigation burdens indistinguishable from tort or contract suits and destabilizing the efficient adjudication model ERISA was enacted to preserve.

Second, there is no circuit split. Courts of appeals uniformly apply a consistent legal framework limiting discovery in ERISA benefit cases, allowing it only in narrowly defined circumstances. Petitioner's attempts to recast case-specific applications of that standard as a doctrinal conflict does not provide a compelling reason for review by this Court. *See* Sup.Ct.R.10(a)–(c).

Third, Petitioner's Petition is premised on a number of mischaracterizations of the Seventh Circuit's decision. The court did not invent a new rule or expand judicial doctrine—it simply declined to rewrite the Plan's language or infer duties not found in ERISA or federal common law. The decision faithfully applied long-settled law to the facts before it.

Finally, this case is a poor vehicle for review. Petitioner failed to take advantage of the full range of procedural rights available during the administrative appeal: Petitioner submitted no medical documentation, including notes from Dr. Ahuja, requested no plan records, and did not take advantage of the opportunity to appear before the Trustees. Having made no effort to build the record, and having made no showing that discovery was warranted, Petitioner now seeks to shift the burden onto the plan administrators and courts through sweeping discovery that ERISA was designed to avoid.

For each of these reasons, the Petition should be denied.

I. The Well-Established Limits on Discovery Are Grounded in ERISA's Statutory Framework and Do Not Warrant This Court's Review.

As a general matter, Petitioner's challenge to the restriction on discovery beyond the administrative record ignores the fundamental structure and purpose of ERISA. Courts uniformly recognize that the general rule limiting judicial review to the administrative record—and allowing discovery only in exceptional cases—is essential to achieving the core policy goals that Congress embedded in ERISA: efficiency,

uniformity, predictability, and the protection of plan assets for the benefit of participants. *See Metro. Life Ins. v. Glenn*, 554 U.S. 105, 117, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008); *Conkright v. Frommert*, 559 U.S. 506, 519, 130 S. Ct. 1640, 176 L. Ed. 2d 469 (2010); *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981–82 (7th Cir. 1999); *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1025 (4th Cir. 1993); *Jewell v. Life Ins. Co. of N. Am.*, 508 F.3d 1303, 1309 (10th Cir. 2007); *Eldridge v. Wachovia Corp. Long-Term Disability Plan*, No. 06-12193, 2007 WL 117712, at *2 (11th Cir. Jan. 18, 2007). Neither the Seventh Circuit nor other circuits' methods for review of benefit-denial decisions are contrary to these stated goals—they are in furtherance of them.

While ERISA was enacted to protect the interests of plan participants and beneficiaries, by regulating the manner in which plans process benefits claims, it was also enacted to protect "contractually defined benefits" in a manner which encourages employers to voluntarily step into the role of fiduciaries and to take on the expense and burden of establishing and administering employee benefit plans for their employees. *Glenn*, 554 U.S. at 120, 128 S. Ct. 2343, (Roberts, C.J. concurring); *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 830, 123 S. Ct. 1965, 155 L. Ed. 2d 1034 (2003). To that end, ERISA emphasizes internal administrative processes, giving plan administrators the initial authority to determine benefit eligibility, with courts generally requiring claimants to exhaust those administrative remedies before resorting to litigation. *Angevine v. Anheuser-Busch Cos. Pension Plan*, 646 F.3d 1034, 1037 (8th Cir. 2011); *Stephens v.*

Pension Benefit Guar. Corp., 755 F.3d 959, 965 (D.C. Cir. 2014).

Thus, the purpose of judicial review under ERISA § 502(a)(1)(B)) is not to mirror traditional civil litigation; rather, it is a specialized proceeding, often limited to the administrative record, in which courts assess whether the plan administrator acted within the bounds of its discretion or, under *de novo* review, whether the claimant was entitled to benefits under the plan's terms. S*ee Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989). To allow broad discovery in every ERISA case would undermine this streamlined process, increasing the cost and complexity of litigation and thereby deterring employers from offering ERISA-covered plans at all—contrary to the stated purpose of the statute.

Finally, because ERISA plans are often funded with assets held in trust for the benefit of all participants, every dollar spent defending against expansive litigation—including unnecessary discovery—diminishes a plan's ability to pay future benefits. Courts have repeatedly emphasized that preserving plan assets is a fundamental goal under ERISA, which justifies limiting extraneous litigation costs. *See Varity Corp. v. Howe*, 516 U.S. 489, 514, 116 S. Ct. 1065, 134 L. Ed. 2d 130 (1996); *Sec'y of Lab. v. Doyle*, 675 F.3d 187, 202 (3d Cir. 2012); *Brogan v. Holland*, 105 F.3d 158, 164 (4th Cir. 1997); *Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir. 1980) ("[T]he institution of such administrative claim-resolution procedures was... intended by Congress to help reduce the number of frivolous lawsuits under ERISA; to promote the consistent treatment of claims for benefits; to provide a

nonadversarial method of claims settlement; and to minimize the costs of claims settlement for all concerned.").

Petitioner's assertion that courts have invented discovery restrictions with "no foundation in ERISA" misstates both the statutory framework and the role of the judiciary in interpreting it.[3] Far from being extra-textual, the principles limiting discovery outside the administrative record stem from ERISA's language, structure, and purpose, and the Supreme Court's guidance in *Firestone* and *Glenn*. Courts do not impose artificial hurdles as Petitioner suggests; rather, they implement ERISA's design as a remedial scheme that favors internal plan resolution and limited judicial intervention while also protecting plan participants.

In other words, the discovery rules implemented by the courts are not "judicial inventions"; they are practical extensions of ERISA's text and objectives. And, contrary to Petitioner's suggestion, these rules

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[3] Petitioner's contention that judicial limitations on discovery in ERISA cases lack a statutory foundation was not raised in the courts below and is therefore waived. The Supreme Court "is 'a court of final review and not first view,' and it does not '[o]rdinarily ... decide in the first instance issues not decided below.'" *City of Austin v. Reagan Nat'l Advert. of Austin, LLC*, 596 U.S. 61, 76–77, 142 S. Ct. 1464, 212 L. Ed. 2d 418 (2022) (alterations in original) (quoting *Zivotofsky v. Clinton*, 566 U.S. 189, 201, 132 S. Ct. 1421, 182 L. Ed. 2d 423 (2012)); *see also Sprietsma v. Mercury Marine*, 537 U.S. 51, 56 n.4, 123 S. Ct. 518, 154 L. Ed. 2d 466 (2002) ("Because this argument was not raised below, it is waived."). Petitioner's new framing—that courts have created discovery restrictions "with no foundation in ERISA"—is not only incorrect, but improperly raised for the first time at this stage.

do not prevent meritorious claims from succeeding. ERISA plaintiffs remain fully able to recover benefits where administrators act arbitrarily or violate procedural requirements. What they are not entitled to, under ERISA's design, is the full sweep of civil discovery untethered to the purpose of reviewing an administrative decision made under a governing plan.

In this case, the district court and Seventh Circuit properly applied these settled ERISA principles in determining to deny discovery, preserving the statute's balance between fair adjudication and efficient, nationally uniform resolution of benefit claims. Petitioner's attempt to upend that framework—through generalized policy critiques divorced from the facts of this case—offers no basis for certiorari.

II. There Is No Circuit Split Warranting Review.

A "circuit split" only exists when "the decision of a federal court of appeals, as to which review is sought, is in direct conflict with a decision of another court of appeals on the same matter of federal law or on the same matter of general law as to which federal courts can exercise independent judgments." *See* Stephen M. Shapiro et al., SUPREME COURT PRACTICE § 4.4 (11th ed. 2019). The conflict relied on "must be direct, with a case in another appellate court or a Supreme Court decision *that is substantially indistinguishable*." *Id.* § 6.31.(a) (emphasis added); *see also* Sup. Ct. R. 10(a) (describing a "compelling reason[ ]" for certiorari as when "a United States court of appeals has entered a decision in conflict with the decision of another United States court of appeals on the same important matter"). Minor factual distinctions, divergent outcomes based on differing records, or differences in language that do not result in contradictory

legal standards do not amount to a split that warrants this Court's intervention. *See* Stephen G. Breyer, *Reflections on the Role of Appellate Courts: A View from the Supreme Court*, 8 J. APP. PRAC. & PROCESS 91, 96 (2006).

As discussed more below, courts uniformly agree that, under an arbitrary and capricious standard of review, discovery outside the administrative record is disfavored and may be permitted only in limited circumstances, such as where a structural conflict of interest exists or procedural irregularities justify expansion beyond the record. Differences in how courts apply that standard when faced with varying factual circumstances do not create the kind of entrenched, outcome-determinative conflict that merits this Court's intervention.

A. All Circuits Apply a Uniform Legal Standard: Discovery Is Generally Disfavored, but Permitted in Narrow Circumstances.

In *Firestone*, 489 U.S. 101, 109 S. Ct. 948, this court explained that ERISA "abounds with the language and terminology of trust law" and that Congress expected that the courts would develop a "federal common law of rights and obligations under ERISA-regulated plans." *Id.* at 110, 109 S. Ct. 948 (citation omitted). Citing principles of trust law, the Court ruled that when an ERISA-governed plan grants discretionary authority to the plan administrator, the administrator's decisions on benefit claims should be reviewed with deference.[4] *Id.* at 111, 109 S. Ct. 948.

[4] Petitioner claims that application of federal common law trust principles is erroneous. (Pet.2.) If Congress believed this Court's

An ERISA plan administrator bears a dual fiduciary obligation: to ensure that a health plan's assets are used to pay covered medical claims for eligible participants while ensuring that non-covered claims are rejected. A trustee breaches its duty by failing either charge. That principle underscores why courts evaluate potential conflicts of interest with care, not presumption. While a plan administrator may have an inherent structural conflict, efforts to mitigate that conflict are entirely consistent with fiduciary duties.

Prior to *Firestone*, the review in ERISA cases was limited to determining whether the benefit denial was arbitrary and capricious. *Id.* at 107, 109 S. Ct. 948. The limitation imposed by *Firestone* reflects ERISA's goal of providing an efficient, predictable dispute-resolution process. Though *Firestone* left open the issue of what evidence may be considered by a federal court in an action under ERISA § 502(a)(1)(B) when *de novo* review is required (*see Hall v. UNUM Life Ins. Co. of Am.*, 300 F.3d 1197, 1201 (10th Cir. 2002)), *Firestone* did not suggest, and no court has held, that full civil discovery is available as a matter of right in ERISA cases.

This Court's decision in *Glenn*, 554 U.S. 105, 128 S. Ct. 2343, did not alter that framework. *Glenn* recognized that structural conflicts—such as when the entity determining eligibility also pays benefits—can be "a factor" in the review, but it did not mandate discovery or expand the administrative record. *Id.* at 108, 128 S. Ct. 2343. Indeed, this Court specifically

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interpretation of ERISA were inaccurate, it has had more than 35 years to amend ERISA to correct the error. Tellingly, Congress has declined to do so.

declined to impose a "one-size-fits-all" procedural or evidentiary rule, explaining that doing so would "create further complexity, adding time and expense to a process that may already be too costly for many of those who seek redress." *Id.* at 116-17, 128 S. Ct. 2343. The decision instead emphasized that the abuse-of-discretion standard remains the default when a plan gives fiduciaries that authority.

To the extent courts across the circuits vary in how they manage discovery outside of the administrative record, those differences are minor and context-specific. Contrary to Petitioner's assertions, *all* circuits recognize that under an arbitrary and capricious standard of review—the standard of review applied in this case—discovery is limited to the administrative record with limited exceptions.[5] The variation in the application of this rule reflects the fact-intensive nature of these determinations, not any genuine legal split.

For instance, as set forth in *Perry*, the Sixth Circuit explained that "[p]ermitting or requiring district courts to consider evidence from both parties that was not presented to the plan administrator would seriously impair the achievement" of a primary goal of ERISA—"to provide a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously." *Perry v. Simplicity Eng'g*, 900 F.2d 963, 967 (6th Cir. 1990) (citing 1974 U.S.

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[5] Petitioner does not contend that the lower courts applied the improper standard of review as grounds for this Court's review. Accordingly, Petitioner's assertions about the limitations of discovery in benefit denial cases reviewed under a *de novo* standard of review are irrelevant and should be disregarded as such.

Code Cong. & Admin. News 4639, 5000). Doing so, the court explained, would result in employees and beneficiaries receiving less protection than what was intended by Congress. *Perry,* 900 F.2d at 967.

The Fifth Circuit similarly provides that, where the plan administrator has "discretionary authority to determine eligibility for benefits or to construe the terms of the plan," courts must base their review of both the legal and factual findings of the administrator's decision under an abuse of discretion standard. *See Anderson v. Cytec Indus., Inc.*, 619 F.3d 505, 512 (5th Cir. 2010) (per curiam) (quoting *Firestone*, 489 U.S. at 115, 109 S. Ct. 948). Under that standard, review of an appeal of a denied claim is limited to the record that was before the administrator when the final claim decision is made. *See Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 299 (5th Cir. 1999) (*overruled on other grounds by Glenn*, 554 U.S. 105, 128 S. Ct. 2343) ("A long line of Fifth Circuit cases stands for the proposition that, when assessing factual questions, the district court is constrained to the evidence before the plan administrator.").

The Fourth Circuit, too, limits review to the record before the administrator under the arbitrary and capricious standard of review. *See Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003, 1007 (4th Cir. 1985) (holding that the trial court improperly admitted evidence which was not before the plan administrator). The court reasoned that, "[t]o review *de novo* all the evidence trustees *might* have considered is to transfer the administration of benefit and pension plans from their designated fiduciaries to the federal bench. Such substitution of authority is plainly what the formulated standards in this field are intended to prevent." *Id.*

While not an exhaustive list, other circuits similarly limit review to the administrative record subject to limited exceptions. *See Abatie v. Alta Health & Life Ins.*, 458 F.3d 955, 970 (9th Cir. 2006); *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 440 (3d Cir. 1997) (*abrogated on other grounds as stated in Miller v. American Airlines, Inc.*, 632 F.3d 837, 847 (3d Cir. 2011); *Murphy v. Deloitte & Touche Grp. Ins. Plan*, 619 F.3d 1151, 1157 (10th Cir. 2010).

In addition to these, other cases relied on by Petitioner similarly reflect a uniform practice in prohibiting review outside the administrative record under an arbitrary and capricious standard of review. *See Dorris v. Unum Life Ins. Co. of Am.*, 949 F.3d 297, 304 (7th Cir. 2020) (citing *Dragus v. Reliance Standard Life Ins. Co.*, 882 F.3d 667, 674 (7th Cir. 2018)) ("[I]n ERISA benefits claims subject to arbitrary and capricious review because the plan gives the administrator discretion, we generally do not look to any evidence beyond what the administrator considered."). *See also Harris v. Lincoln Nat'l Life Ins.*, 42 F.4th 1292, 1296 (11th Cir. 2022) ("We limit review to the administrative record '[w]hen conducting a review of an ERISA benefits denial under an arbitrary and capricious standard' because 'the function of the court [in such a case] is to determine whether there was a reasonable basis for the decision, based upon the facts as known to the administrator at the time the decision was made." (alterations in original) (citation omitted)).

Moreover, even those cases relied on by Petitioner applying a *de novo* standard of review—which does not apply here—reflect the same stated principles favoring limited or no discovery in ERISA denial of

benefit cases. For example, in *Jewell*, 508 F.3d at 1308, the court explained that "[c]onfining review in general to the administrative record, and thus encouraging the parties to develop the factual record as fully and as early as possible, is important for a variety of reasons related to the goals of ERISA." Similarly, in *Murphy*, 619 F.3d at 1163, the court explained that, even when discovery is permitted, discovery is limited in its scope to matters concerning potential conflicts of interest:

> [W]hile discovery may, at times, be necessary to allow a claimant to ascertain and argue the seriousness of an administrator's conflict, Rule 26(b), although broad, has never been a license to engage in an unwieldy, burdensome, and speculative fishing expedition. *See* Fed.R.Civ.P. 26(b) & (b)(2); *see also Crawford–El v. Britton,* 523 U.S. 574, 598, 118 S. Ct. 1584, 140 L.Ed.2d 759 (1998) ("Rule 26 vests the trial judge with broad discretion to tailor discovery narrowly.").

These same limitations apply when the decision is reviewed under an arbitrary and capricious standard of review. *See Bell v. Ameritech Sickness & Accident Disability Benefit Plan*, 399 F. App'x 991, 998 (6th Cir. 2010) ("Discovery may be appropriate to determine the weight to accord to a conflict of interest...."); S*emien v. Life Ins. Co. of N. Am.*, 436 F.3d 805, 815 (7th Cir. 2006) ("Discovery will be allowed into the motivations of a plan administrator or into the motivations of 'independent' physicians only where the claimant has made a prima facie showing of misconduct or conflict of interest."); *Troiano v. Aetna Life Ins.*, 844 F.3d 35, 45 (1st Cir. 2016) (explaining that,

before discovery will be permitted, the beneficiary "bears the burden of showing that the conflict influenced the Plan administrator's decision in some way.").

To the extent Petitioner tries to conflate the two standards of review in an attempt to manufacture a so-called circuit split, Petitioner again ignores the fundamentally different roles the court plays under each standard. That is, under a *de novo* review, the court functions as an independent factfinder, determining in the first instance whether the claimant is entitled to benefits under the plan's terms. *Kearney v. Standard Ins.*, 175 F.3d 1084, 1088 (9th Cir. 1999). Because the court is not limited to assessing the reasonableness of the administrator's decision, it may consider evidence beyond the administrative record where necessary to conduct a full and fair evaluation of the claim. *Luby v. Teamsters Health, Welfare & Pension Tr. Funds*, 944 F.2d 1176, 1184 (3d Cir. 1991).

By contrast, under the arbitrary and capricious standard, the court's role is far more limited: it reviews only whether the plan administrator's decision was reasonable based on the record that was before it at the time. *See Brehmer v. Inland Steel Indus. Pension Plan*, 114 F.3d 656, 660 (7th Cir. 1997). Courts applying this deferential standard do not reweigh evidence or resolve factual disputes, and thus discovery outside the administrative record is generally disallowed—except in narrow circumstances, such as where a claimant makes a threshold showing of a conflict of interest or procedural irregularity. This distinction preserves the efficiency and predictability that Congress intended when it enacted ERISA, while respecting the discretion that plan sponsors often reserve to administrators.

Thus, while circuits may apply the discovery standard with slight variations based on the circumstances, the governing principles are materially the same. That is, every court of appeals recognizes that discovery may be allowed in exceptional cases, such as where there is evidence of a conflict of interest, procedural irregularity, or bias. No such evidence was presented in this case.

Finally, Petitioner's claim that broad discovery is warranted because the administrative record is "unilaterally" created by plan administrators is both inaccurate and reflects a misunderstanding of the governing regulations set forth in 29 C.F.R. § 2560.503–1. ERISA provides claimants with multiple opportunities to contribute to and shape the administrative record during the claims and appeal process—opportunities Petitioner chose not to use in this case.[6] *See Hamburg v. Life Ins. Co. of N. Am.*, 470 F. App'x 382 (5th Cir. 2012). The administrative record is not a one-sided

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[6] App.15a:

> The Plan explicitly provides that a claimant can submit additional documents, comments, materials, or statements to the Fund for consideration—regardless of whether they were previously included in the administrative record. Suzanne Gifford did not submit anything further—for instance, Dr. Ahuja's surgical note, statements or impressions from Dr. Ahuja or any other treating physician, attestations to discussions with treating providers leading up to the surgery, or declarations containing the medical opinion that the aneurysm required emergency surgery. The Plan also allows a claimant to request to review all relevant information used to deny the appeal, free of charge. Such a review might shed light on any documents missing from the administrative record. However, that review was not requested.

compilation, but rather the product of a process that allows for claimant participation and supplementation. *Lane v. Structural Iron Workers Loc. No. 1 Pension Tr. Fund*, 74 F.4th 445, 452 (7th Cir. 2023). If a participant fails to submit evidence during the administrative process, he is not entitled to a second chance to prove he is entitled to benefits or to "quarrel with" the benefit determination. *Murphy*, 619 F.3d at 1159; *Jewell*, 508 F.3d at 1313 (citation omitted). Accordingly, Petitioner cannot now invoke broad discovery as a remedy for strategic choices or omissions made during the very process designed to ensure a full and fair review.

In sum, Petitioner's assertion that there is a circuit split mischaracterizes the legal landscape and ignores the distinction between the two standards of review applicable in ERISA benefits litigation. Under the arbitrary and capricious standard—applied in this case—courts review only whether the plan administrator's decision was reasonable based on the record before it at the time. That limited inquiry, as recognized by every circuit, forecloses broad discovery and precludes expansion of the administrative record except in narrow circumstances. Petitioner attempts to blur this distinction by citing cases that apply a *de novo* standard, where the court acts as an independent factfinder and may, in some instances, consider evidence outside the administrative record. But conflating these two frameworks distorts ERISA's carefully structured process and does nothing to establish a genuine circuit split.

B. The Seventh Circuit's Approach to Discovery in This Case Aligns with Well-Settled Law.

Petitioner argues that the lower courts, including the Seventh Circuit, have improperly restricted discovery in ERISA cases by refusing to permit evidence outside the administrative record. Specifically, Petitioner contends that the Seventh Circuit's decision here and in other cases conflicts with other circuits' approach on when to allow discovery when faced with a potential conflict of interest. (Pet.14-15.) Petitioner is wrong.

Under *Semien*, 436 F.3d 805 and its progeny, a claimant may obtain limited discovery on a conflict-of-interest issue, but only upon a threshold showing that the conflict plausibly affected the benefit determination. There, the Seventh Circuit held that discovery in a case challenging a plan administrator's benefits determination is permissible only in "exceptional circumstances" when the claimant can "identify a specific conflict of interest or instance of misconduct" and "make a prima facie showing that there is good cause to believe limited discovery will reveal a procedural defect in the plan administrator's determination." *Semien*, 436 F.3d at 815.

As the lower court pointed out in this case, following this Court's decision in *Glenn*, the Seventh Circuit recognized "a softening, but not a rejection, of the standard announced in *Semien*." (App.29a.) Under *Glenn*, conflicts "are but one factor among many that a reviewing judge must take into account." (App.28a. (citing *Glenn*, 554 U.S. at 116, 128 S. Ct. 2343).)

The Seventh Circuit explained that *Glenn* is interpreted to mean that the "'*likelihood* that the conflict of interest influenced the [plan administrator's] decision' is key." (App.29a. (quoting *Dennison v. MONY Life Ret. Income Sec. Plan for Emps.*, 710 F.3d 741, 746–47 (7th Cir. 2013) (benefits review officers should not be subjected to extensive discovery on thinly based suspicions that their decision was tainted by conflict of interest). Importantly, the court explained that "[w]ithout a doubt, post-*Glenn*, trial courts still 'retain broad discretion to limit and manage discovery' under Federal Rule of Civil Procedure 26." (App.29a-30a. (quoting *Dennison*, 710 F.3d at 747).) Thus, the Seventh Circuit does not require "conclusive proof" of a conflict before allowing discovery as Petitioner suggests. (*See* Pet.4.) Instead, the Seventh Circuit requires a colorable basis for the request. *See Dennison*, 710 F.3d at 747.

In this case, the district court and the Seventh Circuit correctly concluded that Petitioner failed to make the necessary threshold showing entitling it to discovery, and their decisions were both well-reasoned and supported by law:

> Here, the district court did not abuse its discretion in granting the Fund's motion for a protective order. It first recognized that there was reason to doubt that this case presents the same structural conflict of interest identified in *Glenn*. In contrast to cases involving a single-employer plan in which the employer or insurer has both discretion to determine eligibility of benefits and pays benefits when due, the Plan here is a multi-employer plan administered by a Board of Trustees, which

is composed of an equal number of union and management representatives. Those Trustees voted unanimously to deny Suzanne Gifford's appeal. As in *Marrs*, there is no indication from the record that the Board of Trustees "labored under a conflict of interest serious enough to influence [its] decision consciously or unconsciously—a decision that was otherwise entirely reasonable." *Marrs*, 577 F.3d at 789; *see also Manny v. Cent. States, Se. & Sw. Areas Pension & Health & Welfare Funds*, 388 F.3d 241, 243 (7th Cir. 2004) (no conflict of interest where multi-employer plan with equal number of employer and union representatives on appeals committee ruled unanimously and lacked incentive to rule against claimant).

Aside from this structure, the Board of Trustees also utilized independent medical reviewers to examine the record on appeal. *See Raybourne v. Cigna Life Ins. Co. of New York*, 700 F.3d 1076, 1082 (7th Cir. 2012) (active steps can be taken to "reduce potential bias and to promote accuracy"). While the Estate asserts that there is a conflict of interest between the independent medical review firms and the Fund, this allegation has no support in the record. Contrary to the Estate's allegations, both independent medical reviewers represented that they do not accept compensation for reviews dependent upon a particular outcome and certified in their reports that they had no "material, familial, or financial conflict of interest" with

> the referring entity, the health plan, the plan administrator, or the plan fiduciary or employees, among others.
>
> This is not a borderline case—the Trustees' denial decision has "rational support in the record" and the district court was free to exercise its discretion in limiting discovery to the administrative record. *See Rabinak v. United Bhd. of Carpenters Pension Fund*, 832 F.3d 750, 755 (7th Cir. 2016). Likewise, the Estate presents no evidence of misconduct that might justify discovery outside of that record. *See Semien*, 436 F.3d at 815. The district court thus appropriately exercised its discretion in denying discovery outside of the administrative record and granting the Fund's motion for a protective order.

(App.30a-31a.)

The Seventh Circuit's decision was not erroneous, and Petitioner's reliance on *Demer v. IBM Corp. LTD Plan*, 835 F.3d 893 (9th Cir. 2016), is misplaced. In *Demer*, the Ninth Circuit acknowledged the potential conflict of interest arising from financial relationships between independent medical reviewers and the plan. *Id.* at 901. However, the facts of *Demer* are vastly different from those in this case. In *Demer*, the conflict was substantiated by concrete evidence, including the fact that the medical reviewers had repeatedly been hired by the defendant insurer to render opinions in favor of denial of claims. *Id.* In addition, the court only analyzed whether its review should be "tempered by skepticism" as a result of the alleged conflict of interest, not whether the claimant should be entitled to take discovery. *Id.* at 899-900.

In contrast, here, Petitioner did not present similar evidence or a credible basis to suggest that the two independent medical reviewers in this case were biased or lacked objectivity. As the Seventh Circuit noted, "[w]hile the Estate asserts that there is a conflict of interest between the independent medical review firms and the Fund, this allegation has no support in the record." (App.30a-31a.) Both independent medical reviewers represented that they do not accept compensation for reviews dependent upon a particular outcome and certified that they had no conflicts of interest with the referring entity, the health plan, the plan administrator, or the plan fiduciary or employees. (App.31a.)

Thus, *Demer* does not compel a different outcome here because it involved specific and significant evidence of bias that is absent from the current case. Therefore, the Seventh Circuit's ruling denying Petitioner's request for discovery was consistent with both the facts and the applicable law.

More fundamentally, this Court does not grant certiorari merely because different circuits have reached different conclusions on similar facts. *See Taylor v. Riojas*, 592 U.S. 7, 141 S. Ct. 54, 208 L. Ed. 2d 164 (2020) (per curiam) (holding that disagreement over the application of a properly stated rule of law to a particular set of facts is not the sort of conflict that ordinarily warrants this Court's review). Nor is certiorari appropriate to resolve variability in discretionary decisions, such as whether discovery is necessary in a given case. *See* Sup. Ct. R. 10(a)–(c). That cases in other circuits have resulted in different outcomes represents the type of variation that is fact-driven and discretionary, not a conflict in legal doctrine.

Indeed, Petitioner's reliance on this Court's acknowledgement in *Glenn* that a "one-size-fits-all" approach would be inappropriate in this context only underscores the reasons why Petitioner's proposal is unworkable and why this issue is not worthy of this Court's review. (Pet.20.) That is, like other courts, it illustrates that the absence of a uniform discovery rule is intentional and appropriate given the fact-specific nature of ERISA litigation and the deferential standard of review applicable in most cases. The Federal Rules of Civil Procedure give district courts broad discretion to manage discovery under Rule 26, and the appellate decisions cited by Petitioner merely reflect differences in how courts exercise that discretion on different records.

III. The Seventh Circuit's Decision Properly Applies ERISA Principles and the Plan's Terms to the Record Before It.

Petitioner asserts that the Seventh Circuit's decision in this case conflicts with other circuits' interpretations of ERISA's full and fair review requirement under ERISA § 503. (Pet.21.) Although Petitioner opens by discussing Respondent's interpretation of the term "emergency"—a separate issue unrelated to the full and fair review requirement—the crux of the argument appears to rest on Respondent's alleged failure to obtain a missing surgical note. (Pet.21–22.) But, as discussed more below, ERISA does not impose on plan administrators an obligation to seek out records that were never submitted or identified by the claimant during the administrative process, particularly when the claimant was afforded a full opportunity to supplement the record but failed to do so. *See Jewell*, 508 F.3d at 1309, discussed *infra*.

Relying again on the Fourth Circuit's decision in *Garner v. Central States, Southeast & Southwest Areas Health & Welfare Fund Active Plan*, 31 F.4th 854 (4th Cir. 2022), Petitioner argues that the Fund failed to perform a full and fair review by not obtaining medical records it had no reason to believe existed. (Pet.24-25.) Petitioner criticizes the Seventh Circuit for concluding that *Garner* is distinguishable, and again attempts to manufacture a circuit split where none exists.

In *Garner*, the plaintiff underwent spinal surgery after an MRI, ordered due to worsening back and neck pain, confirmed the need for the procedure. 31 F.4th at 856. The plan denied coverage, deeming the surgery medically unnecessary. During the administrative appeal, an independent reviewer noted that the MRI report and supporting office visit notes were missing from the file and cited their absence in concluding the surgery was unjustified. *Id.* at 857–58. Although the plan possessed the MRI report, it failed to provide it to the reviewer and relied on that incomplete assessment in denying the claim. The Fourth Circuit held that the plan's failure to supply critical medical records in its possession undermined the fairness of its review. Providing the MRI report to a second reviewer did not cure the error, since the plan relied on both reports—one of which was based on an incomplete record. *Id.* at 859.

The Seventh Circuit correctly rejected Petitioner's reliance on *Garner*, finding that unlike in *Garner*, the Fund did not possess the allegedly missing record and had no reason to know it existed. (App.18a.) Moreover, the court noted that the surgical note in question primarily reflected intraoperative findings—

not a preoperative assessment of the necessity or urgency of surgery—and thus added little to the emergency determination central to Petitioner's claim. (*Id.*)

Moreover, both independent medical reviewers considered the complete medical records provided by the hospital and articulated reasoned, well-supported conclusions that the surgery was not required on an emergency basis. (*See* App.20a-21a.) The Trustees' reliance on those reports was entirely proper. *See Williams v. Aetna Life Ins.*, 509 F.3d 317, 324 (7th Cir. 2007).

The Seventh Circuit also correctly held that ERISA does not impose a duty on administrators to track down unspecified or unknown medical documents not submitted during the administrative process. The court noted that "[r]esponsibility for any undiscovered evidence lies with [the claimant]," who is best positioned to provide such information. (App.15a (quoting *Lane*, 74 F.4th at 452–53).) Petitioner failed to submit the surgical note they now claim was critical, even though the Plan allowed them to supplement the record freely and to request all documents used in the appeal decision. They did neither. As the court emphasized, ERISA's review process is "collaborative," but not one-sided; administrators are not expected to guess what evidence might exist. (App.15a.)

The reasoning offered by the Seventh Circuit in this case is consistent with other circuits and ERISA's governing framework. The regulations properly place the onus on the claimant—not the plan—to provide the necessary information to support a benefits claim. ERISA ensures that claimants are given a meaningful opportunity to present evidence and supplement the

administrative record—as Petitioner was here—but it does not require plan administrators to act as investigators or advocates on the claimant's behalf. *See Hamburg*, 470 F. App'x 382; *Lane*, 74 F.4th at 452 (explaining that the administrative record is not unilaterally created by plan administrators but is shaped through a process allowing claimant participation and input). Where, as here, a claimant fails to submit relevant records during the administrative process despite having the opportunity to do so, they are not entitled to later fault the plan for reaching a decision based on the record that was available. *See Murphy*, 619 F.3d at 1159 (rejecting attempt to supplement the record post hoc and emphasizing that ERISA does not entitle claimants to a second chance to prove entitlement to benefits); *Jewell*, 508 F.3d at 1313 (holding that a claimant cannot "quarrel with" the denial of benefits based on evidence never presented during the administrative process (citation omitted)).

Petitioner's position would impose open-ended duties on plan administrators to hunt for unspecified documents that claimants themselves failed to submit. That result would defeat the efficiency and finality ERISA is designed to preserve. The decision below affirms, rather than undermines, that statutory purpose. For these reasons, too, the Petition should be denied.

IV. This Case Is a Poor Vehicle for Certiorari Review.

Even if this Court were inclined to revisit standards governing discovery or the duties of plan administrators and employers under ERISA, this case would be a poor vehicle to do so. As explained above, Petitioner maintained control over its level of

participation in the appeal process. Notwithstanding the fact that Petitioner did not submit additional records—including the opinions of Dr. Ahuja—Petitioner now seeks to impose post hoc obligations that neither ERISA nor the Plan requires. The Seventh Circuit's decision turned squarely on the record before it and involved no legal conclusion that conflicts with other appellate authority.

The district court's protective order—which precluded discovery beyond the administrative record—was likewise well within the court's discretion. As the Seventh Circuit held, there was no evidence of misconduct, structural conflict, or bias. The Plan is a multi-employer trust administered by a balanced board of employer and labor representatives. That board unanimously denied the appeal after consulting two independent neurosurgeons, each of whom certified that they had no conflict of interest. (App.31a.); *see also Marrs*, 577 F.3d at 789. The mere fact that a plan both pays benefits and evaluates claims does not, standing alone, create a discovery-entitling conflict. *Glenn*, 554 U.S. at 117, 128 S. Ct. 2343.

In sum, this case presents no conflict in legal standards, no abuse of discretion, and no compelling reason for this Court's review. The lower courts faithfully applied settled Seventh Circuit precedent, consistent with this Court's guidance in *Glenn*, and correctly found no basis to expand discovery beyond the administrative record. Petitioner's repeated dissatisfaction with the outcome does not transform a routine application of well-settled law into a question of national importance. Because this case lacks the factual and legal complexity necessary to serve as a suitable vehicle for revisiting discovery standards under ERISA,

and because it presents no circuit split or pressing legal issue, the petition for a writ of certiorari should be denied.

CONCLUSION

For the foregoing reasons, this Court should deny the Petition.

Respectfully submitted,

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