No. 24-1080

IN THE

Supreme Court of the United States

SUZANNE GIFFORD, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF MICHAEL GIFFORD,

Petitioner,

v.

OPERATING ENGINEERS 139 HEALTH BENEFIT FUND,

Respondent.

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

REPLY BRIEF FOR PETITIONER

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REPLY BRIEF FOR PETITIONER

I. Respondent Implicitly Concedes That No Statute or Federal Rule of Civil Procedure Supports Respondent's Position.

Operating Engineers 139 Health Benefit Fund (the Fund) argues that the judicially-invented rules that effectively preclude plaintiffs from using basic discovery in Employee Retirement Income Security Act (ERISA) cases are grounded in ERISA's "statutory framework." Response 16. And yet, the Fund's Response does not quote any ERISA statutory language that even plausibly supports the Fund's position. That silence is telling.

Without any statutory basis to support its position, the Fund is instead forced to rely on a combination of what it refers to as "federal common law," as well the problematic "legislative acquiescence" theory. Response 14-18 n.4. Of course, in other areas, the Court has long-recognized that "there is no federal common law." *Erie Railroad Co. v. Tompkins*, 304 U.S. 64, 78 (1938). And courts have been skeptical of so-called "legislative acquiescence." *Rapanos v. United States*, 547 U.S. 715, 750 (2006) (absent "*overwhelming evidence*" that "Congress considered and rejected the '*precise* issue' presented before the Court," the Court is "loath to replace the plain text and original understanding of a statute with an amended agency interpretation.") (citations omitted); *Bob Jones Univ. v. United States*, 461 U.S. 574, 600 (1983) ("Ordinarily, and quite appropriately, courts are slow to attribute significance to the failure of Congress to act on particular legislation.").

The Court should recognize the Fund's repeated references to ERISA's "statutory framework" and "ERISA's text," Response 16, followed by its repeated failure to quote any statutory language to support its argument, for what it is: the Fund admitting that ERISA's plain language does not support the Fund.

Even more stunningly, the Fund claims that its refusal to pay for Mr. Gifford's emergency medical treatment was based on the Fund's alleged concern for "the benefit of [plan] participants," *id.* 14—as though leaving Mrs. Gifford with hundreds of thousands of dollars' worth of unpaid medical bills somehow constitutes empathy, much less fulfills the Fund's fiduciary duty to the Estate.

As the lower court in this case acknowledged: "[t]his is a tragic case." And what the Fund repeatedly lauds as "efficient" resolution of ERISA claims is, in reality, the now-commonplace denial of ERISA claims with no meaningful judicial review—even though no statute actually mandates that result. Instead, a judicially-invented doctrine is making it much more difficult for ERISA plaintiffs to recover than it is for virtually every other plaintiff, and this all despite the fact that ERISA is a remedial statute that was designed to make it easier for ERISA plaintiffs to recover, not more difficult.

The Court should end this troubling practice, and return ERISA plaintiffs to equal footing with other plaintiffs. Plan administrators owe fiduciary duties to claimants. They should not be able to cloak

their denials from review by hiding behind invented prohibitions on discovery—particularly when, as here, the plan had a conflict of interest.

The Fund also tellingly fails to even address the fact that the plain language of the Federal Rules of Civil Procedure (FRCP) also does not support the Fund's argument. Rule 1 provides that the FRCP "govern the procedure in all civil actions and proceedings in the United States district courts, except as stated in Rule 81." Rule 81 does not list ERISA cases as an exception. Similarly, Rule 2 provides that "[t]here is one form of action—the civil action." And yet, for years, lower courts have invented rules that deprive ERISA claimants from using even basic discovery.

Petitioner's concerns are not idle or speculative. In this case, the lower court admitted that, as a result of its ruling, "[p]atients and family members are . . . faced with a gut-wrenching Hobbesian choice of mulling over dense plan provisions or scheduling services in accordance with a treating physician's concern that delay would be catastrophic." App.28a. And while claimants suffer, plan administrators deny meritorious claims with impunity, merely by 'burying their heads in the sand' and ignoring relevant evidence, without disclosing to claimants the evidence upon which they relied to deny the claim.

As this Court observed: "ERISA imposes higher-than-marketplace quality standards on insurers. It sets forth a special standard of care upon a plan administrator, namely, that the administrator 'discharge [its] duties' in respect to discretionary

claims processing 'solely in the interests of the participants and beneficiaries' of the plan, . . . it simultaneously underscores the particular importance of accurate claims processing by insisting that administrators 'provide a full and fair review of claim denials.'" *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008) (citations and quotations omitted) (cleaned up). The current law does not meet this higher-than-marketplace quality standard. It should.

II. There Is a Circuit Split Regarding When ERISA Plaintiffs are Entitled to Engage in Discovery.

The Fund grudgingly concedes that lower courts apply discovery standards differently, but it attempts to downplay those differences by claiming that they are only "slight variations . . . . ." Response 25. But lower courts are applying the FRCP drastically differently, which is causing unnecessary confusion, and is proving to be unworkable. Lower courts have split on how to address those issues, including: (1) when discovery is allowed; and (2) if discovery is generally prohibited, when to apply exceptions. Petition 13-20.

For example, some courts have rightfully confirmed that ERISA litigation is subject to the same procedural framework as other civil actions. *See, e.g.*, *Price v. Hartford Life & Acc. Ins. Co.*, 746 F. Supp. 2d 860, 865 (E.D. Mich. 2010) (the FRCP "provide district courts with means of addressing pretrial discovery issues in ERISA benefits cases so that the interests of economy, efficiency, accuracy, and fairness are all served," and because no "special rules or procedures

are necessary or appropriate," discovery disputes in ERISA cases should be addressed using the FRCP); *see also Murphy v. Deloitte & Touche Grp. Ins. Plan*, 619 F.3d 1151, 1162 (10th Cir. 2010).

Some courts have recognized that ERISA plaintiffs should be able to use the FRCP to support their claims. *See Myers v. Prudential Ins. Co. of Am.*, 581 F. Supp. 2d 904, 912 (E.D. Tenn. 2008) (interpreting *Glenn* as a warning against establishing special evidentiary procedures to apply to interest/bias issues that arise in denial-of-benefits cases, instead reasoning that ERISA plaintiffs should be able to use the tools that other plaintiffs are able to use); *see also Hogan-Cross v. Metro. Life Ins. Co.*, 568 F. Supp. 2d 410, 414 (S.D.N.Y. 2008) (finding insurer's argument against discovery to be "misguided" in light of *Glenn*).

However, other lower courts have all but eliminated discovery in ERISA cases. App.28a. But there are required exceptions to that general prohibition, including when there is a conflict of interest. *See Glenn*, 554 U.S. at 108 (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)). But lower courts do not uniformly follow *Glenn*, and most simply cite it rather than faithfully apply it. *See, e.g.*, *Dennison v. MONY Life Ret. Income Sec. Plan for Emps.*, 710 F.3d 741, 747 (7th Cir. 2013) (indicating that *Glenn* only represented a "softening" of the rigid prohibition against most discovery).

In this case, the Seventh Circuit refused to allow the Estate to engage in *any* discovery, and then faulted the Estate for not proving that the Fund had

a conflict of interest. App28a-29a. That is a nearly impossible standard. Indeed, it would be the rare plan administrator that would openly confess to an impermissible conflict-of-interest, and virtually no plan administrator would be foolish enough to include any bias or conflict-of-interest information in its unilaterally-selected administrative record. As such, if the Court allows lower courts' decisions to stand, *Glenn*'s rule—that conflicts of interest are but "one" factor that courts must consider—will effectively be a dead letter. The Fund determined whether Mr. Gifford was eligible for benefits, and would have been responsible for paying those benefits, which brought this case squarely within the scenario identified in *Glenn*. *See* 554 U.S. at 109.

And although the Seventh Circuit's decision acknowledged that "[c]onflicts are but one factor among many that a reviewing judge must take into account," the Seventh Circuit's decisions are in conflict with other Circuits on how, for example, to prove that there is a conflict of interest, and when to apply one or more of the "many" other factors that courts consider when determining whether to allow discovery. App.28a-29a. The Court should resolve these conflicts, and provide clear guidance on the discovery to which ERISA plaintiffs are entitled.

At a bare minimum, the Seventh Circuit should not have split from other Circuits, and should have permitted discovery into the financial relationship between the Fund and the two purportedly independent reviewers, and how often the reviewers—which were paid by the Fund, and therefore had an incentive to opine in the Fund's favor—opined that

the Fund should deny benefits to its beneficiaries. *See Demer v. IBM Corp. LTD Plan*, 835 F.3d 893, 901-02 (9th Cir. 2016) (financial considerations may create a conflict for purportedly "independent" medical reviewers, and discovery on that issue "is comparable to conventional approaches to discrediting the testimony of retained experts whose objectivity may be challenged based on, *e.g.*, the number of times he or she has served as an expert in support of a party and the amount of compensation received."). As courts have noted, without discovery, most plaintiffs simply cannot present conclusive evidence of bias.

In addition, some Circuits recognize that a plan administrator's fiduciary obligations require the administrator to actually comply with fiduciary obligations. That can include locating and then considering pertinent medical records. Other Circuits purport to hold plan administrators to a fiduciary duty standard, but effectually rubber-stamp any administrator decision. In this case, the court of appeals joined the latter, effectively relieving the Fund of any fiduciary obligations.

The Fund argues that the Estate could have supplemented the record, Response 25 n.6, but because the Fund did not even provide the Estate with a list of the records that it reviewed, the Estate: (a) had no practical way of knowing that the Fund was missing records; and (b) was entitled to rely on the Fund's fiduciary obligations in order to believe that the Fund would not ignore critical medical records.

This Court should grant review in order to resolve these Circuit splits, and to clarify that ERISA

plaintiffs seeking benefits should not face a heavier burden than other civil plaintiffs seeking benefits under any other insurance contract.

A. ERISA Plaintiffs Should Be Entitled to Use the Same Discovery Tools Available to other Plaintiffs.

There is no reason to think that applying the FRCP to ERISA cases would be any more complicated than applying the FRCP to any other civil case.

Moreover, as other cases have explained, private plan administrators are not disinterested governmental entities, meaning they should not be afforded the same deference. *Nagele v. Elec. Data Sys. Corp.*, 193 F.R.D. 94, 106 (W.D.N.Y. 2000). Plan administrators may be laypersons "without any legal, accounting or other training preparing them for their responsible position, often without any experience in or understanding of the complex problems arising under ERISA, and, as this case demonstrates, little knowledge of the rules of evidence or legal procedures to assist them in factfinding." *Luby v. Teamsters Health, Welfare, & Pension Tr. Funds*, 944 F.2d 1176, 1183 (3d Cir. 1991).

Additionally, "the decisions of administrative law judges . . . are usually detailed and based on a plethora of medical data and a transcript of an evidentiary hearing," and that "thorough administrative consideration assures the court has before it the complete record upon which the agency acted as well as a full explanation for the action, thus providing a basis for meaningful, while deferential,

review of a denied claim without the need for further development or clarification of the record through discovery." *Nagele*, 193 F.R.D. at 106.

In addition, adopting a strict prohibition on discovery "effectively grants discretionary decisions by plan administrators to deny benefits 'a uniquely privileged position in the entire field of administrative . . . law.'" *Id.* (quoting *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 983 (7th Cir. 1999) (Wood, J., dissenting)). However, "[s]uch a rule finds no support within the text of ERISA or the [FRCP] applicable to discovery, effectively insulates decisions by fiduciaries adverse to beneficiaries from meaningful judicial review as mandated by ERISA and is contrary to the common law of trust litigation." *Id.*

In other insurance claims, a "judge would not dream of forbidding the parties to take discovery . . . . Evidence is essential if the court is to fulfill its fact-finding function. Just so in ERISA litigation." *Krolnik v. Prudential Ins. Co. of Am.*, 570 F.3d 841, 843 (7th Cir. 2009). Similarly, there is no reason to believe that "evidence of a claims' adjuster's credibility, or of that of the consultant, can be determined solely from the administrative record." *Toven v. Metro. Life Ins. Co.*, 517 F. Supp. 2d 1171, 1173 (C.D. Cal. 2007).

And applying the plain text of the FRCP would not be overly burdensome: courts would still maintain all of their traditional tools for limiting unnecessary discovery. *Walker v. AT&T Benefit Plan No. 3,* 338 F.R.D. 658, 662 (C.D. Cal. 2021).

The Court should clarify that the FRCP mean what they say: ERISA cases are not an exception. In doing so, the Court would: (a) bring ERISA cases back within the plain text of the FRCP; (b) allow district courts to apply familiar rules that they repeatedly apply in run-of-the-mill civil litigation; and (c) place ERISA plaintiffs back on equal footing with other plaintiffs.

III. The Seventh Circuit's Decision Is In Conflict With How Other Circuits Have Construed the Full and Fair Review Requirement.

Plan administrators have fiduciary duties to plan participants, and a duty to provide a full and fair review. 29 U.S.C. § 1133(2). A "full and fair" review requires significantly more effort than the Fund provided in this case. And yet, the Seventh Circuit's decision gave the Fund extraordinary leeway to relieve itself of nearly all fiduciary obligations that it promised to Mr. Gifford.

In response, the Fund claims that *Garner v. Central States, Southeast & Southwest Areas Health & Welfare Fund Active Plan*, 31 F.4th 854 (4th Cir. 2022), is distinguishable, Response 32-35. However, *Garner* is directly on-point, and highlights the Circuit-split. Petition 21-26.

The Fund argues that even though the Fund did not have the surgical note, it was still able to make a reasoned and informed decision, because the Fund claims that it "had no reason to know [the surgical note] existed." Response 33. That argument is akin to

an umpire calling a strike, only to later admit that a camera caught him missing the pitch altogether because he was instead looking at something in the stands. In either scenario, the decisionmaker cannot make a reasoned and informed decision, as *Garner* requires.

Relatedly, the Fund argues that the surgical note was irrelevant because it "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." Response 33. But the Fund did not make its denial determination the day before the July 7, 2021, surgery based on the only records available on July 6, 2021. The Fund made its denial decision in November 2021, several months after the July surgery. Given that, and in order to comply with its fiduciary obligations, the Fund should have made its decision based on *all* of the evidence that was available in November 2021, which included the July surgical note that further confirmed the neurosurgeon's diagnosis that, based on the July 6 angiogram, Mr. Gifford needed emergency surgery. That is particularly true in the ERISA context, where benefits coverage is liberally construed, and exemptions are applied narrowly. *See, e.g.*, *Carrabba v. Randalls Food Markets, Inc.*, 38 F. Supp. 2d 468, 477 (N.D. Tex. 1999).

The Fund's request—that plan administrators be permitted to 'bury their heads in the sand' when it comes to relevant evidence that was available when the plan administrator actually made its decision, which the Seventh Circuit's decision implicitly

encourages—runs directly contrary to the Fourth Circuit's *Garner*.

Garner is directly on-point, and provides the better-reasoned analysis with regard to a plan administrator's fiduciary obligations. Petition 21-26. Indeed, even the Seventh Circuit's decision conceded that the practical effect of its rule left patients faced with the "gut-wrenching Hobbesian choice of mulling over dense plan provisions or scheduling services in accordance with a treating physician's concern that delay would be catastrophic." App.28a.

In *Garner*, the Fourth Circuit explained that, when a plan administrator fails to provide its "independent" reviewers with pertinent but available medical records, "[n]one of the virtues of an independent evaluation are present when the evaluator is denied the very evidence necessary to come to a reasoned judgment." 31 F.4th at 858; *see also Glenn*, 554 U.S. at 123-24 (administrator's "failure to provide its internal experts with all the relevant evidence of [the plaintiff's] medical condition" constituted evidence that the administrator abused its discretion) (Roberts, C.J., concurring).

In this case, the Fund likewise failed to provide a reasonable review. The decision below has created a split between, at minimum, the Seventh and Fourth Circuits. As the Fourth Circuit held, at a minimum, complying with fiduciary obligations should mean giving principled, good faith consideration to a claimant's pertinent medical records before denying a

claim—even if the administrator does not learn about the records until after the initial denial.

IV. This Case Is an Appropriate Vehicle to Address the Conflicting Issues.

The Seventh Circuit's decision exacerbates the ongoing split between Circuits. The Court should clarify the scope of an administrator's fiduciary obligations, and what factors courts should consider to determine whether discovery is appropriate.

Accordingly, this case is an appropriate vehicle to address and resolve both issues.

CONCLUSION

The Court should grant the Petition.

Respectfully submitted,

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