NO. _____

In the Supreme Court of the United States

MICHAEL CLOUD,

Petitioner,

v.

THE BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN,

Respondent.

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

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

In *Firestone Tire & Rubber Co. v. Bruch*, the Court set forth the standard of review for denials of benefits provided by employers under the Employment Retirement Income Security Act of 1974 ("ERISA"). While *de novo* review was the standard, the Court held, where plan documents grant deferential authority to administrators, the standard shifts to an abuse of discretion. Subsequent decisions by the Court clarified how to weigh factors like an ERISA plan's conflict of interest in administering and funding benefits and reinforced the deference owed to an administrator's interpretation of plan terms, but the Court has not weighed in on the deference, if any, owed to significant procedural violations. As a result, there is an entrenched conflict within the circuit courts, with the Second Circuit and Ninth Circuit employing a strict adherence standard and default *de novo* review, respectively, where such violations are found, the Eleventh Circuit treating procedural violations as a matter of statutory and regulatory compliance as a matter of law that must be reviewed *de novo*, and the Fifth Circuit, Seventh Circuit, and other circuits maintaining a more deferential substantial compliance review. To resolve these issues, the questions presented are:

1. Whether significant procedural violations of ERISA require *de novo* review, strict adherence, or some other heightened standard that does not defer to Plan administrators absent harmless procedural irregularities.

2. If *Firestone*'s holding applies to significant procedural violations by an ERISA plan administrator, whether *Firestone* should be reconsidered.

LIST OF PROCEEDINGS

Cloud v. The Bert Bell/Pete Rozelle NFL Player Retirement Plan, No. 22-10710 (5th Cir.) (judgment entered October 6, 2023 and revised on March 15, 2024).

Cloud v. The Bert Bell/Pete Rozelle NFL Player Retirement Plan, Civil Action No. 3:20-CV-1277-S (N.D. Tex.) (judgment entered June 27, 2022).

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INTRODUCTION

The National Football League ("NFL") has failed to reckon with the devastating physical and cognitive injuries that lead to lifelong impairments for retired players. Although the NFL ostensibly provides disability benefits through The Bert Bell/Pete Rozelle NFL Player Retirement Plan ("Respondent" or the "Plan"), investigative reports and Congressional hearings have revealed substantial evidence that the Plan, "jointly managed by the league and union, . . . fights aggressively to deny claims and repeatedly shirks legal obligations to fairly review cases . . . . " Will Hobson, *How the NFL Avoids Paying Disabled Players—with the Union's Help*, Wash. Post, Feb. 8, 2023, https://www.washingtonpost.com/sports/2023/02/08/nfl-disability-players-union/; Will Hobson, *The Broken Promises of the NFL Concussion Settlement*, Wash. Post, Jan. 31, 2024, https://www.washingtonpost.com/sports/interactive/2024/nfl-concussion-settlement/.

Federal courts have likewise found that the Plan fiduciaries have a long history of acting as "adversar[ies], not [as] fiduciar[ies]" to the detriment of retired NFL players, the Plan's beneficiaries. *Dimry v. Bert Bell/Pete Rozelle NFL Player Ret. Plan*, 487 F. Supp. 3d 807, 818 (N.D. Cal. 2020); *see also Armstrong v. Bert Bell NFL Player Ret. Plan*, 646 F. Supp. 1094, 1095 (D. Colo. 1986) ("Each time [Plaintiff] nears the goal line and is about to obtain the disability benefits which the plan promises to injured players, the yard markers are changed and the clock is stopped.")

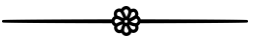
Petitioner Michael Cloud ("Cloud") is a retired NFL player who sustained several major concussions

during his career, including a violent helmet-to-helmet collision that forced him to retire and ultimately changed his life. He sought disability benefits under the Plan when he was unable to sustain employment following his NFL career due to his cognitive impairments. After multiple attempts, Cloud was granted lower-level disability benefits by the Plan. The Plan, however, refused to give him the appropriate level of benefits. Cloud brought suit, and following a bench trial, the district court agreed that the Plan had wrongfully denied him benefits. Through its extensive findings of fact and conclusions of law, the district court revealed a system rigged against former players like Cloud, noting that "[b]ehind the curtain is the troubling but apparent reality that these abuses by the [Plan fiduciaries] are part of a larger strategy engineered to ensure that former NFL players suffering from the devastating effects of severe head trauma are not awarded [the highest level of] benefits." Pet.App. 125a. The Fifth Circuit agreed that Cloud was likely eligible for the level of benefits he sought and acknowledged the Plan's failure to provide him with a full and fair review, noting "we share the district court's unease with a daunting system that seems stacked against disabled ex-NFLers." Pet.App.17a. Nonetheless, the Fifth Circuit reversed the district court and ruled in favor of the Plan on the ground that the Plan's denial of Cloud's benefits did not amount to an abuse of discretion. Five circuit judges opposed the Fifth Circuit's denial of *en banc* review, with one authoring a dissenting opinion.

There is an entrenched circuit split on whether *Firestone* requires courts to apply an abuse of discretion standard where there are significant procedural

deficiencies. That standard has significant implications for former players, as evident in Cloud's case where it was dispositive to the outcome, and other beneficiaries. The Court should review this case to resolve this conflict to ensure the Plan's consistent failure to provide a full and fair review does not impact former players differently depending on the circuit in which they find themselves.

To the extent that *Firestone*'s holding extends to procedural deficiencies, the Court should grant review to reconsider that aspect of its decision. As various critics have noted, what began as an attempt to impute the highest standards of care to plan fiduciaries has devolved into courts rubberstamping administrator decisions, even those on the lowest end of the "continuum of reasonableness," as noted by the Fifth Circuit in its decision below. *See* Pet.App.14a. This case also presents an ideal vehicle for the Court to consider these issues because the procedural violations were so egregious and the district court's findings were so extensive, yet the Fifth Circuit refused to even consider them. In another circuit, the outcome would have almost certainly been different.



OPINIONS BELOW

The Fifth Circuit's initial opinion, reported at 83 F.4th 423, was withdrawn and substituted with the opinion reported at 95 F.4th 964 (and reprinted in the Appendix ("Pet.App.") at 1a-19a) following its denial of panel rehearing and *en banc* rehearing. The opinion denying rehearing and rehearing *en banc* is reported at 95 F.4th 974 and reprinted at Pet.App.130a-145a.

The district court's opinion has to yet been published but is reported at 2022 U.S. Dist. LEXIS 109943 and 2022 WL 2237451 and reprinted at Pet. App.20a-129a.

JURISDICTION

The Fifth Circuit entered its revised opinion on March 15, 2024. App.1a. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

U.S. Const. art. III § 1:

> The judicial Power of the United States, shall be vested in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish. The Judges, both of the supreme and inferior Courts, shall hold their Offices during good Behaviour, and shall, at stated Times, receive for their Services, a Compensation, which shall not be diminished during their Continuance in Office.

29 U.S.C. § 1104(a)(1) provides, in pertinent part, as follows:

> (a) Prudent man standard of care
>
> (1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the

interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III.

29 U.S.C. § 1132 provides, in pertinent part, as follows:

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

* * *

(B) to recover benefits due to him under the terms of his plan, to enforce his rights

> under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

29 U.S.C. § 1133 provides, in pertinent part, as follows:

> In accordance with regulations of the Secretary, every employee benefit plan shall—
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

STATEMENT OF THE CASE

A. ERISA Framework

ERISA requires plan administrators to provide: (1) adequate written notice of a denial of benefits, clearly stating the specific reasons for the denial; and (2) full and fair review of a denied claim for benefits. 29 U.S.C. § 1133. Regulations promulgated by the Department of Labor provide minimum procedural requirements to comply with § 1133, including taking into account all documents and information submitted by the claimant regardless of whether they were considered in the initial determination (29 C.F.R. § 2560.503-

1(h)(2)(iv)) and consulting with a health care professional with appropriate training and experience where claims are based on medical judgments (29 C.F.R. § 2560.503-1(h)(3)(iii)). These regulations provide "the applicable standard of care, skill, and caution that plans must follow when exercising their discretion" to determine benefits eligibility. *Halo v. Yale Health Plan*, 819 F.3d 42, 52 (2d Cir. 2016).

Under ERISA Section 502(a)(1)(B), "[a] civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Such suits are typically brought for wrongful denial of benefits or failure to comply with one or both of the procedural requirements provided in § 1133.

B. Factual Background

Cloud played as a running back in the NFL from 1999 to 2006, before the NFL concussion protocol was in place. Throughout his career, Cloud suffered at least seven major concussions, which ultimately forced him to retire. *See generally*, Pet.App.25a-27a. "[P]rior to retiring, he experienced debilitating neurological and cognitive impairments, including various psychiatric and psychological disabilities, which have become progressively worse since his retirement." Pet.App. 21a. These disabilities arose directly from the head injuries he sustained while playing in the NFL, including, in particular, a high speed, in-game, helmet-to-helmet collision on October 31, 2004. Pet.App.26a. Cloud became unable to remember plays after the October 2004 collision, so after bouncing between teams, he was forced to retire at the end of the 2005 NFL season

in January 2006. Subsequently, he tried to obtain gainful employment as a personal trainer, California State Trooper, and a sportscaster, but he was unable to perform the functions of these jobs due to his neurological injuries. As a result, he sought disability benefits from the Plan. "However, like many other former players suffering from the effects of head trauma, [Cloud] was forced to navigate a byzantine process in order to attempt to obtain those benefits, only to be met with denial." Pet.App.21a.

1. Overview of Plan Benefits and Procedures

The Plan arose out of collective bargaining between the league's Management Council ("NFLMC") and NFL Players Association ("NFLPA"). Pet.App.24a. The Plan distinguishes between Line of Duty Disabilities ("LOD") (permanent, substantial disablement arising out of an NFL career) and Total & Permanent Disabilities ("T&P"). There are four classifications of T&P Disabilities: Active Football, Active Nonfootball, Inactive A, and Inactive B, with different benefits associated with each classification.

The Plan Benefits Office ("Benefits Office") handles the daily administration of the Plan. Pet.App.41a. Benefits Office coordinators prepare players' files for review by the Disability Initial Claims Committee (the "Committee"), which determines whether claimants qualify for disability benefits. Appeals are determined by the Retirement Board (the "Board"). The Board consists of six members, three appointed by the NFLPA and three appointed by the NFLMC. The Board relies on a variety of "advisors" to carry out its functions. Among these are the Plan's outside counsel at Groom Law Group, NFLMC lawyers who advise the

NFLMC Board members, and NFLPA lawyers who advise the NFLPA Board members. Pet.App.46a-51a.

The Board is the named fiduciary of the Plan, and the Plan gives the Board "full and absolute" discretion over the Plan, including with respect to interpreting its terms and deciding claims for benefits. Pet.App.28a. However, the Plan requires that both the Committee and the Board act "solely and exclusively" in the interest of the beneficiaries, the retired NFL players. Pet.App.28a. This requirement reflects ERISA's mandate that a plan fiduciary must "discharge its duties with respect to the plan solely in the interests of the participants and beneficiaries." 29 U.S.C. § 1104(a)(1). Notably, the NFLPA has long argued that it does not owe a fiduciary duty to retired players and does not represent retired players like Cloud. *See Eller v. Nat'l Football League Players Ass'n*, 872 F. Supp. 2d 823, 832-34 (D. Minn. 2012).

The Board decides appeals at two-day quarterly board meetings. Pet.App.49a. On the first day, the Board members do not participate. Instead, Groom lawyers, Board advisors, and Benefits Office staff meet and review the cases. On the second day, there are separate, private and undocumented "pre-meetings" for the NFLPA Board members and their advisors and the NFLMC Board members and their advisors to discuss the cases to be decided by the Board at the formal meeting. Pet.App.49a. The advisors present the cases to the Board members but do not provide any documents for the Board to review. Pet.App.49a. The "pre-meetings" between Board members and unknown advisors lasted only ten minutes and addressed 114 disability cases, which amounts to 5.26 seconds spent considering each case. Pet.App.74a. At the formal

meeting, the Board votes in blocks of 50 or more cases "*en masse*" without discussion. Pet.App.50a.

Once decisions are made by the Board (or the Committee in the case of initial determinations), the Benefits Office sends decision letters to the players. In 2016, a Groom paralegal began preparing these decision letters. Pet.App.45a. The letters are not reviewed by the Board (or Committee) before they are sent. Pet.App.45a, 50a.

2. Timeline of Cloud's Attempts to Obtain Benefits

Cloud first applied for benefits under the Plan in 2009. Pet.App.51a. He listed neurological and orthopedic conditions in his application and was referred to a neurologist and an orthopedist, both neutral physicians. The orthopedist evaluated Cloud and determined that he met the threshold rating to qualify for LOD benefits. After receiving the report, the Plan Benefits Office, which handles the initial processing of claims, asked the orthopedist to re-evaluate his report and submit changes. In the revised report, Cloud no longer qualified for LOD benefits. Cloud was never evaluated by the neutral neurologist, and his case was presented to the Committee without a neurological report. Pet.App. 52a. The Committee denied Cloud's request based on the orthopedist's altered rating.

In early 2010, Cloud appealed the Committee's denial. He was again referred to a neutral neurologist, and this time the neurologist was able to evaluate him before his case was sent to the Board. Pet.App.53a. The neurologist reported that Cloud's neurological impairments were very likely the result of his traumatic brain injuries from playing in the NFL and recom-

mended further testing, including an MRI. Pet.App. 53a-54a. However, he was never referred for further testing or an MRI. A neutral orthopedist reported that his physical impairments were rated to receive LOD benefits. About a month later, the Board approved Cloud's LOD benefits. Pet.App.55a.

Cloud applied for and was granted disability benefits by the Social Security Administration ("SSA") in 2014, with an effective onset date of December 31, 2008. Pet.App.62a. Shortly after receiving the SSA award, Cloud applied for T&P benefits under the Plan, which provided for automatic awarding of T&P benefits where a claimant has been determined eligible for disability benefits by the SSA. He submitted various medical reports with his application, but the Committee did not evaluate them or refer him for evaluation by an independent physician. Pet.App.63a-64a. Instead, it granted him T&P, Inactive A benefits based solely on his SSA award. The decision noted that he was not eligible for Active Football benefits because he did not meet the Plan's "shortly after" requirement that an injury that occurs while the player is in the NFL must result in total and permanent disability within six months. Pet.App.64a.

Cloud did not appeal the Committee's decision, but in 2016 he applied for reclassification of his T&P benefits to Active Football. He included the same medical records that he submitted with his 2014 application and an additional medical report and stated that his disabilities began immediately after the October 31, 2004 helmet-to-helmet collision. Pet.App.65a. The Committee again did not refer Cloud for evaluation by a neutral physician and denied his application for reclassification in a letter dated March 2, 2016. The

decision letter cited a lack of evidence of changed circumstances and the SSA award's onset date of December 31, 2008 being well after the required "shortly after" period as reasons for the Committee's denial. Pet.App.67a-68a.

Cloud appealed the Committee's decision. Once again, the Board did not refer him to a physician for evaluation. Pet.App.71a. A case summary prepared by a Groom paralegal erroneously stated that a medical report attached to the 2016 reclassification application had also been attached to the 2014 application for T&D benefits. It also listed symptoms from the 2014 application but not the symptoms Cloud listed in his 2016 application.

Both the decision sheet summarizing the votes at the formal Board meeting and the minutes from that meeting indicated that Cloud's application for reclassification was denied for lack of clear and convincing evidence of changed circumstances. Pet.App.75a, 79a. However, the decision letter prepared by the Groom paralegal, dated November 23, 2016, added additional reasons for denial that were not considered by the Board, including that his T&P disabilities did not arise within the "shortly after" period and that his appeal was untimely under the terms of the Plan. Pet.App.76a-79a.

C. Proceedings Below

On May 15, 2020, Cloud filed a Complaint against the Plan for wrongful denial of benefits and failure to provide a full and fair review in violation of ERISA. After a six-day bench trial, the district court issued an 84-page memorandum opinion and order making extensive findings of fact and conclusions of law and

holding that the Plan failed to provide a full and fair review and abused its discretion in denying Cloud's reclassification. Reviewing the administrative record and available evidence, the court concluded that the Plan abused its discretion in denying Cloud's reclassification application for several reasons. Pet.App.22a. The Board failed to consider Section 5.4(b)'s "Special Rule" that creates an exception to the "shortly after" requirement set forth in Section 5.3(a) to allow T&P benefits for players who meet the requirements for a T&P disability based on psychological or psychiatric disorders caused by head injuries, including repeated concussions, sustained while playing in the NFL. Pet.App.108a-112a. This failure, the district court found, was both legally incorrect and contradicts the plain meaning of the Plan language. "Similarly, the Board's imposition of the 'shortly after' requirement to qualify for Active Football benefits under Section 5.3(a) when the Special Rules under Section 5.4(b) do not contemplate such a requirement is inconsistent with a fair reading of the Plan and entirely lacks support in the administrative record." Pet.App.100a.

The district court also found that the Board abused its discretion by determining that Cloud did not meet the definition of "changed circumstances" to reclassify his benefits because such determination was "inconsistent with a fair reading of the Plan and not supported by concrete evidence in the administrative record." Pet.App.100a. The court noted that the Board has never applied a uniform interpretation of "changed circumstances" and has used various definitions of the term in benefits denial letters, "allow[ing] the Plan to modify its meaning on an ad hoc basis." Pet.App.103a. Further, initial applications based on

SSA benefits are granted automatically without review of the application or administrative record and without referral to a neutral physician. As such, the court noted "it is difficult to conceive how the Board could determine whether the Plaintiff's circumstances had changed in connection with his 2016 reclassification application when there was never an assessment of what his circumstances were to begin with (in connection with his 2014 application)." Pet.App.106a-107a. Because the Board did not investigate or determine what circumstances needed to change to qualify for reclassification in 2016, "there was no connection, much less a rational one, between the facts known to the Board and its determination that Plaintiff had not shown changed circumstances," making the Board's finding arbitrary and capricious and an abuse of discretion. Pet.App.107a.

With respect to the Board's failure to provide a full and fair review, the district court found that it violated ERISA by (1) failing to clearly identify specific reasons for denying Cloud's appeal, (2) not considering all documents and records Cloud submitted with his application, (3) affording deference to the Committee, and (4) failing to consult with a healthcare professional yet basing its decision on a medical judgment. Pet.App.88a. "In doing so, the Board failed to substantially comply with ERISA procedural regulations and denied [Cloud] a meaningful dialogue regarding its denial of [his] reclassification appeal." *Id.* Specifically, the court found that the Board's decision letter states multiple reasons for denial that the undisputed evidence shows were never actually contemplated by the Board but were instead "post hoc rationalizations devised by Benefits Office staff and advisors."

Pet.App.89a. Such "wholesale adoption of its advisors' reasons for denial, without having contemplated all of those reasons [itself], defies any possibility of the 'meaningful review' required by ERISA." Pet.App.89a-90a. Additionally, the district court noted the Board violated ERISA's procedural requirements by relying on advisors to review Cloud's file, including the facts of his case and medical records, without any guidance, which resulted in a Groom paralegal providing the Board members with case summaries that were full of errors. Pet.App.93a-94a. In so relying, the Board failed to consider a medical report and new impairments included in Cloud's 2016 reclassification application. With respect to reliance on the Committee, the district court found that the Board's reliance on the same advisors who had actively participated in the Committee's decision to deny reclassification "creates an inherent appearance of impropriety" and "effectively forecloses the Board's ability to review a player's claim anew in violation of [ERISA's regulatory] mandate to 'not afford deference to the initial adverse benefit determination' and conduct review by an individual who did not 'ma[k]e the adverse benefit determination that is the subject of the appeal.'" Pet.App.96a. Citing 29 C.F.R. § 2560.503-1(h)(3)(iii), which requires plan administrators to consult with a relevant, qualified medical professional where adverse benefits determinations are based on a medical judgment, the district court found that the Board was required to consult a health care professional trained in neuropsychological disabilities to provide Cloud with a full and fair review. Pet.App.96a-98a. Yet, "[t]he Board wholly failed to do so . . . despite having several opportunities to do so over the course of six years." Pet.App.98a.

The district court noted that these violations could not be "characterized as mere technical noncompliance with ERISA's procedural requirements." *Id.* Rather, the district court found that "far from substantially complying with ERISA's procedural requirements, the Board failed to provide . . . a full and fair review . . . and did not fulfill 29 U.S.C. § 1133's purpose of affording [Cloud] an explanation of denial of benefits that is adequate to ensure meaningful review of that denial." Pet.App.98a-99a. Based on Fifth Circuit precedent, the district court noted that finding a failure to provide a full and fair review constitutes "an independent basis to overturn a plan administrator's denial of benefits." Pet.App.99a. (quoting *Truitt v. Unam Life Ins. Co.*, 729 F.3d 497, 510 n.6 (5th Cir. 2013)). Because the district court found the Board's denial was arbitrary and capricious, it ordered the Plan to provide Cloud with Active Football T&P benefits rather than remand the case to the Plan administrator for a full and fair review. Pet.App.128a.

The district court concluded its opinion with stark observations regarding the Board and its efforts to deny Cloud's benefits.

> The Board's review process, its interpretation and application of the Plan language, and overall factual context all suggest an intent to deny Plaintiff's reclassification appeal <u>*regardless of the evidence*</u>. At one juncture, the Social Security Administration's determination of total and permanent disability was accepted without question. But when Plaintiff applied for reclassification in 2016, it was disregarded completely. Instead, and without explanation, the Board substituted

> its own erroneous conclusion that Plaintiff was not totally and permanently disabled, relying on tortuous reasoning in denying Active Football benefits that was contrary to the plain meaning of multiple Plan provisions. Such a determination *based on cherry-picked information favoring denial of Plaintiff's application* is not "the result of a principled reasoning process." *Glenn v. MetLife*, 461 F.3d 660, 674 (6th Cir. 2006), *aff'd sub nom. Glenn*, 554 U.S. 105. And in reaching its decision, the Board relied almost exclusively on compromised advisors, failed to consider important—let alone all—information in Plaintiff's file, and shirked its fiduciary obligations under both ERISA and the Plan itself.

Pet.App.125a-126a (emphases added).

The Plan appealed the district court's decision to the Fifth Circuit, which reversed and remanded the case to the district court to enter judgment in favor of the Plan. The Fifth Circuit panel commended the district court for "its thorough findings—devastating in detail—which expose the NFL Plan's disturbing lack of safeguards to ensure fair and meaningful review of disability claims brought by former players who suffered incapacitating on-the-field injuries, including severe head trauma." Pet.App.3a. Acknowledging that the Board may have denied Cloud a full and fair review and that he is "probably entitled to the highest level of disability pay," the panel concluded that the Board did not abuse its discretion in determining that Cloud was not eligible for reclassification because he could not show changed circumstances between his

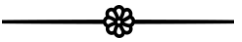
2014 T&P application and his 2016 reclassification claim.[1] Pet.App.3a-4a.

Cloud petitioned the Fifth Circuit for rehearing and rehearing *en banc* asserting that the panel should have applied a *de novo* standard, which was denied with five circuit judges voting in favor of rehearing and eleven voting against. Pet.App.130a-131a. Circuit Judge Graves authored a dissenting opinion in which he noted that Cloud "ma[de] valid assertions with regard to the standard of review" but concluded that the Board's determination should be reversed even under the abuse of discretion standard. Pet.App.136a. Specifically, Circuit Judge Graves argued that the record does not support the panel's conclusion that Cloud could not show changed circumstances in part because Cloud's 2016 application *did* include new disabilities and conditions, including affective disorder and significant memory and attention problems. Pet.App.140a-142a. Additionally, the dissent reasoned, because Cloud's 2014 T&P benefits award was based solely on his eligibility for SSA disability benefits rather than any specific impairment or condition examined or verified by the Plan, he was free to assert the same impairments he did in his 2014 application for the Plan to evaluate for the first time. Like the district court, Circuit Judge Graves's dissent found the Board's review process troubling, noting "[t]he board does not individually discuss cases, preferring to deny or approve blocks of 50 or 100 or more cases at a time based on reasons possibly mentioned by someone," and "[t]he record indicates that nobody really reads

[1] This finding contradicts the district court's 6-page examination of changed circumstances and holding that the Board abused its discretion in finding no changed circumstances.

any individual applications or administrative records, there's really no oversight, and a paralegal for outside counsel drafts the denial letters and adds language, often incorrect, that the board never considered or said, as acknowledged by the [Fifth Circuit] panel." Pet.App.139a.

Following its denial of *en banc* rehearing, the Fifth Circuit withdrew its initial opinion and substituted it with the decision reported at *Cloud v. Bert Bell/Pete Rozelle NFL Player Ret. Plan*, 95 F.4th 964 (5th Cir. 2024). *See* Pet.App.1a-19a. None of the changes to the court's opinion are relevant to this petition.



REASONS FOR GRANTING THE PETITION

I. *Firestone* and Its Progeny Have Left the Circuit Courts Conflicted Over the Proper Application of the Standard of Review of an ERISA Plan Administrator's Denial of Benefits

Federal courts have been "bedeviled" by the application of the appropriate standard of review of ERISA benefits denials by plan administrators since the Court first laid out the standard of review in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). *See Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 378 (3d Cir. 2000). In *Firestone*, the Court applied principles of trust law and held that "a denial of benefits challenged under [ERISA section] 1132(a)(1)(B), is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator

or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." 489 U.S. at 115. Where such discretionary authority is granted under the plan, the Court held, the appropriate standard of review is abuse of discretion (or arbitrary and capricious as it is referred to in some circuits). *Id.*

As issues arose in applying *Firestone* deference in the courts of appeals, the Court subsequently clarified the standard of review with respect to conflicts of interest and reinforced the deference owed to plan administrators' interpretation of plan terms. In *Metropolitan Life Insurance Company v. Glenn*, the Court held that while a conflict of interest is present where the plan administrator also funds the plan, such a conflict should be considered a factor in determining the appropriate standard of review but does not change the standard itself. 554 U.S. 105 (2008).

In *Conkright v. Frommert*, the Court held that, absent an abuse of discretion, deference is afforded to a plan administrator's reasonable interpretation of plan terms even if a court previously found the administrator's initial interpretation of that term to be incorrect. 559 U.S. 506, 509 (2010).

These three decisions leave unclear, however, the extent to which *Firestone* deference applies to judicial review of ERISA procedural challenges. Circuit courts apply different standards in this context, resulting in anything but uniform results for plan participants and beneficiaries.

The Ninth Circuit, sitting *en banc*, has held that flagrant violations of ERISA procedural requirements

alter the standard of review from abuse of discretion to *de novo*. *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006) (en banc). Explaining the circumstances "in which procedural irregularities are so substantial as to alter the standard of review," the Ninth Circuit panel stated:

> When an administrator engages in wholesale and flagrant violations of the procedural requirements of ERISA, and thus acts in utter disregard of the underlying purpose of the plan as well, we review de novo the administrator's decision to deny benefits. We do so because, under *Firestone*, a plan administrator's decision is entitled to deference only when the administrator exercises discretion that the plan grants as a matter of contract. 489 U.S. at 111. *Firestone* directs, consistent with trust law principles, that "a deferential standard of review [is] appropriate when a trustee *exercises* discretionary powers." *Id.* (emphasis added). Because an administrator cannot contract around the procedural requirements of ERISA, decisions taken in wholesale violation of ERISA procedures do not fall within an administrator's discretionary authority.

Id. at 971-72.

The Eleventh Circuit reviews all ERISA procedures, flagrant or not, *de novo*, reasoning plan administrator's compliance "with the procedural aspects of the applicable statutes and regulations and the interpretation of ERISA, a federal statute, is a question of law subject to *de novo* review." *Boysen v. Ill. Tool Works, Inc.*, 767 F. App'x 799, 806 (11th Cir. 2019)

(noting "none of the relevant authorities expressly provides a governing standard of review for determining whether a plan administrator has satisfied the necessary 'minimum procedural requirements' or provided full and fair review.") (internal quotations omitted). The *Boysen* court acknowledged the Ninth Circuit's narrower approach to reviewing procedural violations but declined to follow it. *See id.* at n.1.

The Second Circuit has held that a plan's failure to comply with ERISA procedural regulations will result in *de novo* review, "unless the plan has otherwise established procedures in full conformity with the regulation and can show that its failure to comply with the claims-procedure regulation in the processing of a particular claim was inadvertent *and* harmless." *Halo*, 819 F.3d at 58 (emphasis in original). "Full conformity," according to the Second Circuit, amounts to strict adherence to the regulations. *Id.* at 56. Under *Halo*, a plan "must strictly adhere to the regulation to obtain the more deferential arbitrary and capricious standard of review." *Id.*

Other circuits, including the Fifth Circuit, apply a far more deferential standard to procedural challenges, requiring only that the plan administrator substantially comply with, rather than strictly adhere to ERISA procedural requirements. *See, e.g.*, *Lafleur v. Louisiana Health Serv.*, 563 F.3d 148, 154 (5th Cir. 2009). The substantial compliance standard arose out of judicial application of the initial 1977 ERISA regulations. *Halo*, 819 F.3d at 56. Courts did not want to punish plan administrators for procedural irregularities or mistakes that do not implicate bad faith. *See Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 634 (10th Cir. 2003).

The *Halo* court concluded that the substantial compliance doctrine is "flatly inconsistent" with ERISA regulations that were updated in 2000 to include a subsection allowing claimants to pursue civil actions based on a plan's failure to establish or follow claims procedures consistent with the regulations. *Halo*, 819 F.3d at 50. This new provision was meant to "clarify that the procedural minimums of the regulation are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections *should not be entitled to any judicial deference*." *Id.* (quoting 65 Fed. Reg. at 70,255) (emphasis added). *Halo* held that "a plan's failure to comply with the claims-procedure regulation, 29 C.F.R. § 2560.503-1, will result in that claim being reviewed de novo in federal court" and that "the plan bears the burden of proof on this issue." *Id.* at 57-58. In explaining its holding, the Second Circuit noted:

> [I]f plans comply with the regulation, which is designed to protect employees, the plans get the benefit of both an exhaustion requirement and a deferential standard of review when a claimant files suit in federal court—protections that will likely encourage employers to continue to voluntarily provide employee benefits. But if plans do not comply with the regulation, they are not entitled to these protections. That result is not unnecessarily harsh, as those in favor of the substantial compliance doctrine have contended. The failure to comply does not result in any oppressive consequence; plans will have to pay the claim only if it is a meritorious claim, which they are already contractually obligated

> to do. They will simply lose the benefit of the great deference afforded by the arbitrary and capricious standard. In short, this regulatory approach balances the competing interests of employers and employees and, accordingly, ERISA's dual congressional purposes.

Id. at 56.

Several courts of appeal disagreed and concluded instead that violations of the updated 2000 regulations do not change the standard of review provided, (1) there was a benefits decision, (2) the plan administrator substantially complied with the regulations, and/or (3) the claimant did not demonstrate actual prejudice. *See, e.g.*, *Dimery v. Reliance Std. Life Ins. Co.*, 597 F. App'x 408, 409-10 (9th Cir. 2015) ("ERISA procedural violations do not alter the standard of review unless the violations cause the beneficiary substantive harm."); *Shedrick v. Marriott Int'l, Inc.*, 500 Fed. App'x 331, 338 (5th Cir. 2012) ("Challenges to ERISA procedures are evaluated under the substantial compliance standard."); *Kough v. Teamsters' Local 301 Pension Plan*, 437 Fed. App'x 483, 486 (7th Cir. 2011) ("Under this regulation, substantial compliance is sufficient.").

The strict adherence standard articulated by the Second Circuit, with its narrow exceptions, better protects plan participants and beneficiaries from plan administrators' procedural violations and does not allow courts of appeal to stop their analysis at whether a plan administrator abused its discretion in its interpretation of a plan term or a claimants eligibility for benefits where there are procedural violations of ERISA found by the district court. But not all claimants have access to courts that will apply strict

adherence and as such their benefits determination depends on what jurisdiction they find themselves. In Cloud's case, the Fifth Circuit asked only whether the Plan abused its discretion in denying his reclassification and did not address whether the Plan denied him a full and fair review. Pet.App.17a-18a. Under the stricter standards of review articulated by the Second, Ninth, and Eleventh Circuits, the outcome of Cloud's case would have certainly been different.

II. The Decision Below is Incorrect Because It Allows Egregious Deviations from Procedure That Thwart the Purpose of ERISA

The Fifth Circuit's decision was erroneous because it applied the incorrect standard of review where the district court found extensive procedural violations. The record shows that the Fifth Circuit's lenient review is counter to ERISA's purposes and does not support reversal of the district court.

1. The Panel Overlooked the District Court's Extensive Findings Regarding the Plan's Procedural Violations

The Fifth Circuit failed to use the correct standard of review where the district court and the record extensively established that there were wholesale, flagrant violations of ERISA procedural requirements, which would require *de novo* review in the Ninth Circuit, Second Circuit, and Eleventh Circuit. The court failed to analyze any of the Plan's procedural violations or to weigh any such violations or the Plan's clear conflict of interest as required by *Glenn*.

Both the record and the district court's extensive findings show the Plan egregiously failed to comply

with ERISA's procedural requirements and its own terms. In 2014, the Plan never reviewed the SSA award or Cloud's medical records for an appropriate categorization, instead simply "rubber-stamping" lesser benefits. Pet.App.106a. In 2016, the Plan never reviewed Cloud's newly asserted impairments or records and relied on incoherent purported justifications in "rubber-stamping" the Committee's denial in violation of the terms of the Plan. Pet.App.106a-107a. The Committee and the Board set in motion a process that failed Cloud with an "illogical application of Plan provisions." Pet.App.107a; *see also* 29 C.F.R. § 2560.503-1(b). By failing to take into account any of these procedural violations, the Fifth Circuit's assessment of Cloud's reclassification is simply erroneous. The Plan's benefits denial was worthy of overturning on this basis alone, yet the Fifth Circuit failed to even consider it. *See* Pet.App.99a (citing *Truitt*, 729 F.3d at 510 n.6).

2. The Panel's Overly Lenient Analysis Contravenes the Purpose of ERISA

Rather than undertake the abuse of discretion and substantial compliance analysis required in the Fifth Circuit (and already set out by the district court), the Fifth Circuit questioned only whether the Plan's interpretation of changed circumstances was unreasonable. Pet.App.14a. In doing so, it ignored not only the flagrant procedural violations of the Plan but also substantial evidence available in the record as a whole. Courts are required to review the whole record, using the combination-of-factors method under *Glenn* and the substantial evidence method set out by the Court in *Universal Camera v. National Labor Relations Board*, 340 U.S. 474 (1951). The substantiality of evidence must take into account "contradictory

evidence from which conflicting inferences may be drawn." *Id.* at 487.

However, a recent Fifth Circuit concurring opinion acknowledged that the Fifth Circuit applies the substantial evidence standard incorrectly. *See Michael J.P. v. Blue Cross & Blue Shield of Tex.*, No. 20-30361, 2021 WL 4314316, 2021 U.S. App. LEXIS 28704, at *20-27 (5th Cir. Sept. 22, 2021) (Oldham, J., concurring). Circuit Judge Oldham noted that the Fifth Circuit's approach to substantial evidence review "significantly diverges" from what the Court contemplated in *Universal Camera*. Under the standard used by the Fifth Circuit, ERISA plaintiffs will not prevail even if they support their claims with substantial evidence or a preponderance of evidence as long as the plan administrator's decision is supported by substantial evidence. *Id.* at *25. "Applying this formulation, we often decline to engage in a holistic review of the evidence, because we can readily find that there is some—more than a scintilla even if less than a preponderance—evidence that supports the administrator's decision." *Id.* at *26 (internal citation omitted). In practice, this amounts to approving nearly every plan administrator's decision regardless of what evidence supports the plan beneficiaries' position." *Id.* Circuit Judge Oldham concluded:

> It appears that we've wandered far astray. The Supreme Court warned us not to use [Labor Management Relations Act] principles to review ERISA claims [in *Firestone*]. We did so anyway. And then we adopted a flavor of substantial-evidence review that bears little resemblance to one we'd use in an administrative-law case. All of this makes it

> particularly difficult for ERISA beneficiaries to vindicate their rights under the cause of action created by Congress. And it does so with no apparent support in law, logic, or history.

Id. at *27.

The Fifth Circuit continued its erroneous application of substantial evidence review in Cloud's case. Like the Board, it ignored the additional medical records and conditions he included in his 2016 reclassification application in finding that Cloud could not establish changed circumstances. Pet.App.15a-16a. Instead, it asked only whether the Plan's definition of changed circumstances as stated in Cloud's decision letter was reasonable. The panel stopped its inquiry there despite the Plan's failure to adopt a specific definition of the term "changed circumstances" and its use of various definitions to seemingly justify denials of claims based on specific circumstances. Pet.App. 16a-17a. As Circuit Judge Graves noted in his dissent, "[t]he record does not support the panel's conclusion. Cloud did make a showing of changed circumstances before the committee and before the board [on appeal]." Pet.App.140a.

By ignoring substantial evidence in the record, the Fifth Circuit has denied Cloud the meaningful full and fair review contemplated by ERISA. Congress enacted ERISA to "to promote the interests of employees and their beneficiaries in employee benefit plans[] and to protect contractually defined benefits." *Firestone*, 489 U.S. at 113 (internal citations omitted). Yet, the Fifth Circuit's approach fails to protect those interests and thereby contravenes ERISA's explicit purposes. It

does so at the expense of plan beneficiaries like Michael Cloud.

3. The Fifth Circuit's Decision Requires Setting Aside the District Court's Findings of Fact

The Fifth Circuit panel repeatedly commends the district court for its thorough findings and the disturbing picture they reveal about the Plan and notes that it will only set aside such findings if they are clearly erroneous. Pet.App.3a ("We commend the district court for its thorough findings—devastating in detail—which expose the NFL Plan's disturbing lack of safeguards to ensure fair and meaningful review of disability claims brought by former players who suffered incapacitating on-the-field injuries, including severe head trauma."). The panel did not explicitly set aside any of the district court's factual findings, yet in reversing, the Fifth Circuit in effect did overturn the district court's extensive factual findings despite never having concluded they were erroneous and despite the Plan failing to challenge any of the district court's findings. If the district court's findings reveal "a disturbing lack of safeguards to ensure meaningful and fair review," the Fifth Circuit has effectively set aside those findings by not concluding that the Plan violated ERISA by not providing Cloud a full and fair review. Pet.App.3a. The Court recently noted that a district court's findings that "do[] not float on a sea of doubt but stand[] on firm ground" should not be disturbed. *Nat'l Collegiate Athletics Ass'n v. Alston*, 594 U.S. 69, 107 (2021). The Fifth Circuit "commend[ed] the trial court judge for her diligent work chronicling a lopsided system aggressively stacked against disabled players," but ultimately disturbed those findings to adopt the Plan's post hoc

(and unsupported) rationale for denying Cloud's reclassification. Pet.App.19a.

III. *Firestone* is Ripe for Clarification and Reconsideration

For the reasons above, the first question presented independently warrants the Court's review. But this case also presents the Court with a much-needed opportunity to clarify and reconsider *Firestone*'s scope. "The Supreme Court's opinion in [*Firestone*] garbles long-settled principles of trust law, confuses trust and contract rubrics, and invites plan drafters to defeat the stated objectives of the decision." John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 Sup. Ct. Rev. 207, 228 (1990). In the aftermath of *Firestone*, many, if not all, plans include deferential authority to the plan administrator to give them the advantage of deferential review. As such, the default standard in ERISA cases has become deferential rather than *de novo* review. The practical effect of providing plan administrators, most of whom also fund the plan, with *Firestone* deference absent an abuse of discretion under the principles of trust law is that it puts claimants at a significant procedural disadvantage and has an absolute chilling effect. Not only do they have to establish their eligibility for benefits, but claimants must also show that the plan administrator's denial of benefits was unreasonable, unsupported by substantial evidence, or legally erroneous. Courts have acknowledged that the abuse of discretion standard requires ruling in favor of ERISA plans even where claimants have stronger cases. *See, e.g.*, *Kirkendall v. Halliburton, Inc.*, 760 Fed. App'x 61, 65 (2d Cir. 2019) ("This panel indeed finds the interpretation of the Plan advanced by [claimant] to be more reasonable . . . [,]

but in such cases, under the standard of review we must apply, the administrator's interpretation will not be disturbed by the courts."); *Fessenden v. Reliance Std. Life. Ins. Co.*, No. 3:15-CV-370-PPS, 2018 WL 461105, 2018 U.S. Dist. LEXIS 7754, at *1-2 (N.D. Ind. Jan. 17, 2018) ("I am inclined to believe that [claimant] is in fact disabled by his medical conditions, but oddly, that conclusion is not what dictates the outcome here."). The Fifth Circuit in this case acknowledged as much. *See* Part I(B)(3), *supra*.

ERISA was "enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 830 (2003). Fiduciary and trust law principles may be well suited to charitable trusts,[2] but they are far less so to insurance companies operating for profit. "ERISA imposes higher-than-marketplace quality standards on insurers" and "sets forth a special standard of care upon a plan administrator," which is to process claims "solely in the interests of the participants and beneficiaries" of the plan. *Glenn*, 554 U.S. at 115; *see also Bussian v. RJR Nabisco Inc.*, 223 F.3d 286, 294 (5th Cir. 2000) ("ERISA's duty of loyalty is 'the highest known to the law'"); *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir. 1982) (explaining that fiduciary "decisions must be made with an eye single to the interests of the participants and beneficiaries"). The ability of insurers to ignore their own financial self-interest to act as fiduciaries and conform to the principles of trust law has raised such skepticism that the National

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[2] *Firestone* cites to the Restatement (2d) of Trusts § 187, which summarizes the law of charitable rather than business trusts.

Association of Insurance Commissioners prepared a model law for states to adopt that prohibits the grant of discretionary authority in plan language. *See* NAIC Model Law 42, *Prohibition on the Use of Discretionary Clauses Model Act* (2006), available at https://content.naic.org/sites/default/files/inline-files/MDL-042.pdf ("The purpose of this Act is . . . to avoid the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due."). Several states from across the political-ideological spectrum have adopted this model law or incorporated it into their statutory or regulatory provisions.[3]

Even as states try to limit the deference mandated by *Firestone* and the Department of Labor further restricts plans from judicial deference where administrators do not strictly adhere to ERISA regulatory procedural requirements, *see* 29 C.F.R. 2560.503-1(l)(i), perhaps the most significant reason *Firestone* deference should be reconsidered is that it violates Article III of the United States Constitution. Article

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[3] *See, e.g.*, Arkansas Department of Insurance Rule 101 (2013); California Insurance Code § 10110.6 (2012); Colorado Revised Stat. § 10-3-1116(2) and (3) (2008); Illinois Admin. Code, Tit. 50, § 2001.3 (2005); Maryland Code Ann. Ins. § 12-211 (2011); Michigan Admin. Code R. 500.2201 to 500.2202 (2007); Minnesota Stat. § 60A.42 (although enacted as § 62A.241) (2015); Montana Administrative Register, Issue No. 6, pp. 504-507 (2003); New Jersey Administrative Code § 11:4-58 (2006), but effectively neutralized by *Baker v. Hartford Life Ins. Co.*, 440 Fed. Appx. 66 (3d Cir. 2011); Oregon Admin. Rules § 836-010-0026 (2015); Rhode Island Gen. Laws § 27-18-79 (2013); South Dakota Ins. Code § 20:06:52 et seq. (2008); Texas Admin. Code § 3.1203 (2010); Utah Admin. Code § 590-218 (2003); Washington Admin. Code § 284-44-015 (2009); Wyoming Stat. § 26-13-304 (2009).

III, § 1 grants a constitutional right to "an independent and impartial adjudication by the federal judiciary" for litigants asserting a private right in federal court. *CFTC v. Schor*, 478 U.S. 833, 848 (1986). As a party to the proceedings, the ERISA benefits plan cannot be impartial or independent when it both funds and evaluates claims for eligibility. As such, judicial deference to the decision of a plan administrator in federal court constitutes an impermissible relegation of judicial power in violation of Article III. Congress did not create an Article I tribunal to resolve ERISA disputes (though it considered it), *see* S. Rep. No. 93-127, at 62-64 (1974), or establish a method to allow claimants to waive their Article III rights. It expressly "did not delegate any adjudicative authority to employers or plan administrators when enacting ERISA . . . . " *Downs v. Liberty Life Ass. Co. of Boston*, No. 3:05-CV-0791-R, 2005 WL 2455193, 2005 U.S. Dist. LEXIS 22531, at *19 (N.D. Tex. Oct. 5, 2005). However, the effect of *Firestone* deference is to do just that—delegate adjudicative authority to plan administrators and relegate cases before federal courts to summary review proceedings. In overturning *Chevron*, the Court recently noted that "Article III of the Constitution assigns to the Federal Judiciary the responsibility and power to adjudicate 'Cases' and 'Controversies'—concrete disputes with consequences for the parties involved." *Loper Bright Enters. v. Raimondo*, ___ U.S. ___, 2024 U.S. LEXIS 2882, at *24 (June 28, 2024). Yet in continuing to allow deference to plan administrators under *Firestone*, the Court yields that responsibility and power to one of the parties to the dispute. Additionally, as Cloud's case painfully illustrates, the individuals tasked with administration of eligibility determinations often lack the "specialized

experience" that led the Court to grant deference to agencies in the first place. *See id.* at * 28.

It does not appear that the Court considered the applicability of Article III in *Firestone* or its progeny. Yet, its singular focus on trust principles at the expense of the Article III rights of claimants has the effect of allowing plan administrators to contract around the typical deference granted to trustees. The practical impact on plan beneficiaries, the infringement of their Article III rights, and the misapplication of trust principles make *Firestone* ripe for reconsideration.

IV. This Case is the Ideal Vehicle to Resolve the Questions Presented

Whether the Court grants a writ of certiorari to clarify the standard of review of ERISA benefit denials and procedural challenges or to reconsider *Firestone* altogether, or both, this case provides an excellent vehicle to resolve these issues. The Court would be hard pressed to find a plan with more egregious, flagrant violations in both administration and design than this Plan. The district court's 84 pages of findings of fact and conclusions of law paint a bleak picture of the Plan's procedural failures, noting "[t]he curtain has been pulled back as to the inner workings of [the Plan,] . . . [a]nd what lies behind it is far from pretty with respect to how it handles disability claims sought by former players, such as Michael Cloud." Pet.App.20a. Sadly, Cloud is not the only former player who has had to resort to litigation to fight for his benefits. The Plan has a history of systemic errors treating Plan beneficiaries and acting as adversaries toward beneficiaries like Cloud. *See* Pet.App.126a-127a

(citing seven such cases out of dozens lodged by former players).

Despite the district court's meticulous analysis of the Plan's abuse of discretion in denying Cloud's reclassification claim and of the Plan's failure to substantially comply with ERISA's procedural requirements, the Fifth Circuit merely concluded that the Plan's definition of changed circumstances in Cloud's denial letter was reasonable and therefore not an abuse of discretion. Pet.App.17a. Had Cloud's case been before the Second Circuit under a strict adherence standard or the Ninth Circuit under a *de novo* standard for flagrant procedural violations, as discussed *supra*, the outcome would have been different.

While the Fifth Circuit erred in ignoring the abundance of evidence in the administrative record that demonstrated changed circumstances, much of which the Plan failed to even consider, improperly applying the standard of review, and failing to consider whether the Plan's flagrant violations required a *de novo* review, this case does not turn on those errors alone. Instead, it needs the Court to grant a writ of certiorari to resolve the conflicting applications of the appropriate standard of review that create varying outcomes in different courts of appeals.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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