No. _____

In the Supreme Court of the United States

JANE DOE, PETITIONER

v.

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

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

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

This case presents two acknowledged circuit conflicts regarding how district courts adjudicate benefits claims under the Employee Retirement Income Security Act, 29 U.S.C. 1132(a)(1)(B), when those claims are considered *de novo* under *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989).

Here, despite recognizing that the expert medical evidence conflicted, the district court granted respondents summary judgment and denied petitioner's request to examine the experts. The First Circuit affirmed.

First, the court held that "[i]n the ERISA context, 'the burdens and presumptions normally attendant to summary judgment practice do not apply,'" so the district court can resolve fact conflicts. That holding aligns with the Sixth Circuit, but ten other circuits apply Rule 56 the usual way: "If a paper record contains a material dispute, a trial is essential." *Krolnik* v. *Prudential Ins. Co. of Am.*, 570 F.3d 841, 844 (7th Cir. 2009) (Easterbrook, J.).

Second, the court held that, absent a challenge to the plan's administrative process, district courts are confined to the record before the administrator. That holding entrenches an eleven-circuit, four-way split about the scope of the record for *de novo* ERISA benefits claims.

The questions presented are:

1. Whether, on *de novo* consideration of an ERISA benefits claim, summary judgment must be denied if there is a genuine dispute of material fact.

2. Whether, on *de novo* consideration of an ERISA benefits claim and absent a challenge to the plan's procedures, a district court has discretion to consider evidence that was not part of the record before the plan administrator.

RELATED PROCEEDINGS

United States District Court (D. Mass.):

Doe v. *Harvard Pilgrim Health Care, Inc.*, No. 15-10672 (Aug. 6, 2019)

Doe v. *Harvard Pilgrim Health Care, Inc.*, No. 15-10672 (Oct. 11, 2017)

United States Court of Appeals (1st Cir.):

Doe v. *Harvard Pilgrim Health Care, Inc.*, No. 19-1879 (Sept. 9, 2020)

Doe v. *Harvard Pilgrim Health Care, Inc.*, No. 17-2078 (Sept. 6, 2018)

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Jane Doe respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the First Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-14a) is reported at 974 F.3d 69. The district court's order granting summary judgment (App., *infra*, 15a-51a) is unreported but available at 2019 WL 3573523. The district court's order denying petitioner's request for an evidentiary hearing (App., *infra*, 52a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on September 9, 2020. On March 19, 2020, this Court extended the time within which to file a petition for a writ of certiorari due on or after the order's date to 150 days from the date of the lower court judgment. This Court's jurisdiction is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISION AND RULE INVOLVED

Section 502(a) of ERISA, 29 U.S.C. 1132(a), provides, in pertinent part:

> (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 * * * .

Federal Rule of Civil Procedure 56 provides, in pertinent part:

> (a) Motion for Summary Judgment or Partial Summary Judgment. A party may move for summary judgment, identifying each claim or defense—or the part of each claim or defense—on which summary judgment is sought. The court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law. The court should state on the record the reasons for granting or denying the motion.

INTRODUCTION

Firestone Tire & Rubber Co. v. *Bruch*, 489 U.S. 101 (1989), established that the default standard for adjudicating benefits claims under 29 U.S.C. 1132(a)(1)(B) is *de novo*. The Court emphasized that, unless the plan vests the administrator with discretion, benefits claims should be reviewed like "any other contract claim." *Id.* at 112. To do otherwise would "afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Id.* at 114. And since *Firestone*, this Court has repeatedly rebuffed efforts to create special rules for ERISA claims. See, *e.g.*, *Thole* v. *U.S. Bank N.A.*, 140 S. Ct. 1615, 1622 (2020); *Conkright* v. *Frommert*, 559 U.S. 506, 513, 519 (2010); *Metro. Life Ins. Co.* v. *Glenn*, 554 U.S. 105, 116-117 (2008).

Courts, however, have struggled to implement *Firestone*'s holding. Some, like the First Circuit here, continue to create ERISA-specific procedural rules. These rules are found nowhere in ERISA's text, yet they deviate from what the Federal Rules of Civil Procedure would otherwise require. The First Circuit's decision provides a clean vehicle to resolve two acknowledged circuit splits that arise constantly in ERISA litigation under Section 1132(a)(1)(B)'s *de novo* standard.

First, the court discarded the Rule 56 summary-judgment standard: "[I]n the ERISA context, 'the burdens and presumptions normally attendant to summary judgment practice do not apply.'" App., *infra*, 4a (citation omitted). Instead of asking whether fact disputes remain, the district court examines "'the administrative record'" and "'may weigh the facts, resolve conflicts in evidence, and draw reasonable inferences.'" *Id.* at 5a (citations omitted). Here, some doctors' reports supported petitioner's claim, while others supported respondents' denial of benefits. The First Circuit's understanding of summary judgment,

however, authorized the district court to "agree[] more with [respondents'] experts than with [petitioner's]." *Id.* at 9a.

That holding entrenches a square conflict with every circuit but the Sixth, all of which instruct district courts to deny summary judgment if a genuine issue of material fact remains.

The Seventh Circuit, for instance, expressly rejected the First Circuit's "potentially misleading standard for 'summary judgment'" and "instead appl[ied] the normal rule: *de novo* review, with judgment appropriate if there is no genuine issue of material fact." *Patton* v. *MFS/Sun Life Fin. Distributors, Inc.*, 480 F.3d 478, 484 n.3 (7th Cir. 2007); see also, *e.g.*, *O'Hara* v. *Nat'l Union Fire Ins. Co.*, 642 F.3d 110, 117 (2d Cir. 2011) (reversing district court for "'weigh[ing] competing physician opinions'"); *Kearney* v. *Standard Ins. Co.*, 175 F.3d 1084, 1094 (9th Cir. 1999) (en banc) ("Because the summary judgment is reversed because of a genuine issue of fact, the genuine issue of fact must be resolved by trial.").

The split on this issue is indisputable, and the correct answer is clear. There is no basis to stray from the normal operation of Rule 56 in ERISA cases. "If a paper record contains a material dispute, a trial is essential," so the plaintiff can "offer medical evidence of his own and cross-examine the physicians." *Krolnik* v. *Prudential Ins. Co. of Am.*, 570 F.3d 841, 844 (7th Cir. 2009) (Easterbrook, J.). The First Circuit's conception of summary judgment severs that "essential" procedural right. This Court's intervention is necessary to ensure that summary judgment for Section 1132(a)(1)(B) claims operates the same in every circuit.

Second, the First Circuit held that, absent a challenge to the administrator's procedures, the district court cor-

rectly refused to "supplement[] the administrative record." App., *infra*, 10a. It thus rejected petitioner's request to have "the various experts testify and be subject to cross-examination, as if this were an insurance coverage dispute." *Ibid.*

That decision contravenes *Firestone*'s teaching that a court *should* treat *de novo* claims "as it would * * * any other contract claim." 489 U.S. at 112. And it exacerbates a longstanding, eleven-circuit conflict about the proper scope of evidence in such cases: "The Courts of Appeals have divergent views of how and when a district court can accept evidence outside of the administrative record in de novo review cases and some prohibit it entirely." *Dorris* v. *Unum Life Ins. Co. of Am.*, 949 F.3d 297, 304 n.1 (7th Cir. 2020); see, *e.g.*, *Ariana M.* v. *Humana Health Plan of Tex., Inc.*, 884 F.3d 246, 256 (5th Cir. 2018) (en banc) (circuits "take a variety of positions on whether *de novo* review allows a party to expand the record beyond what was before the plan administrator"); *Hall* v. *UNUM Life Ins. Co. of Am.*, 300 F.3d 1197, 1201 (10th Cir. 2002) (discussing "split" over "the proper evidentiary scope of review in de novo ERISA cases").

At least four distinct approaches have taken root. *One*, the First Circuit and the Sixth Circuit forbid any new evidence (absent a challenge to the plan's administrative procedures). *Two*, the Third, Seventh, and Eleventh Circuits take the opposite position, allowing district courts discretion to consider new evidence as they see fit, just as they would in any other case. *Three*, multiple circuits chart a middle path, where courts can consider additional evidence, but only if they find it "necessary." Notably, each of these circuits would have allowed the testimony petitioner requested here. *Four*, the Fifth Circuit has rejected those three positions in favor of restricting evidence in all but a few limited circumstances.

This conflict cannot stand. It is intolerable to subject ERISA benefits claims to multiple separate procedural regimes depending on where the participant sues.

And the approach adopted by the First Circuit (and the Sixth) is untenable. According to the First Circuit, *de novo* adjudication "takes the form of a review of 'final ERISA administrative decision'" and cannot be treated "as if [it] were an insurance coverage dispute under state law." App., *infra,* 10a (citation omitted). Allowing new evidence would "offend interests in finality and exhaustion of administrative procedures." *Orndorf* v. *Paul Revere Life Ins. Co.*, 404 F.3d 510, 519 (1st Cir. 2005). "[J]udicial review does not 'warrant calling as witnesses those persons whose opinions and diagnosis or expert testimony and reports are in the administrative record.'" App., *infra*, 10a (quoting *Orndorf*, 404 F.3d at 518).

Writing for the Seventh Circuit, Judge Easterbrook explained how that conception of the *de novo* standard fundamentally misconceives the judiciary's role. "[I]t is an independent *decision* rather than 'review' that *Firestone* contemplates." *Krolnik*, 570 F.3d at 843 (emphasis in original). Accordingly, like any other case, "the court takes evidence (if there is a dispute about a material fact) and makes an independent decision about how the language of the contract applies to those facts." *Ibid.*

The Seventh Circuit further demonstrated that the First Circuit here took exactly the wrong lesson from its insurance-law comparison. It is "well understood in insurance litigation" that the court "won't ask what evidence the insurer considered. The court will decide for itself where the truth lies." *Ibid.* Put simply, "[e]vidence is essential if the court is to fulfill its fact-finding function. Just so in ERISA litigation." *Ibid.* And a party "would be free to offer medical evidence of his own and cross-examine the physicians" whose reports "underlie [the administrator's]

decision." *Id.* at 844. The First Circuit's position deprives participants of these essential tools to protect their benefits. Contra *Firestone*, 489 U.S. at 112-114.

Like the Seventh Circuit, most circuits recognize that when a district court must reach an independent decision about a participant's entitlement to benefits, the court must have discretion to admit more evidence than would be permissible in a case involving deference to the plan administrator's decision. The First Circuit's rule directly contradicts those holdings. Review is warranted to impose uniformity in this critical area of ERISA procedure.

STATEMENT

A. Statutory Background

Congress enacted ERISA "'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 (citations omitted). It included a private right of action for a participant or beneficiary "to recover benefits due to him under the terms of his plan." 29 U.S.C. 1132(a)(1)(B). Unless the plan gives the administrator discretion to make benefits determinations or interpret the plan, courts should use a *de novo* standard to evaluate benefit denials under Section 1132(a)(1)(B). *Firestone*, 489 U.S. at 108-115.

In requiring a *de novo* decision (rather than "arbitrary and capricious" review), the Court reasoned that ERISA should not be interpreted to "afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Id.* at 114. Before ERISA's enactment, benefits claims "were governed by principles of contract law." *Id.* at 112. So a "court reviewed the employee's claim as it would have any other contract claim." *Ibid.*

B. Facts And Procedural History

1. a. In 2012, petitioner developed severe symptoms of mental illness. App., *infra*, 19a. Anxiety and depression escalated to recurring psychotic episodes, hallucinations, and homicidal and suicidal ideation. *Ibid.* For much of 2012, petitioner received treatment for these symptoms in outpatient, partial hospitalization, and inpatient settings. See *ibid.*

Eventually, however, petitioner's outpatient team recommended residential treatment at Austen Riggs hospital. *Ibid.* Petitioner was admitted to Riggs in January 2013, where she remained until June 2013 (the "First Admission"). *Ibid.*

During the First Admission, petitioner's symptoms were extreme. See *id.* at 20a-25a. She experienced repeated hallucinations and delusions—including voices telling her to cut herself, visions of "snakes on [her] legs" or in her body, and "paper people coming out of the walls and dancing and then sticking knives in her ankles." *Id.* at 21a-22a. These symptoms culminated with hospital staff finding petitioner bleeding on the bathroom floor, a razor in the sink. *Id.* at 25a. Petitioner told staff that, following a hallucination, she had tried to carve the word "kill" into her leg. *Ibid.* Petitioner's doctors determined that she presented an immediate danger to herself, so she was admitted on June 18 to a hospital that could provide acute inpatient treatment. *Ibid.*

After a week in acute treatment, petitioner returned to Riggs (the "Second Admission"). *Ibid.* During that six-week stay, her condition improved. Although she continued to experience symptoms, she was largely without psychosis or suicidal ideation. *Ibid.* And once her doctors stabilized her medication with a new anti-psychotic drug, petitioner was able to enter a lower level of care. *Id.* at 25a-26a.

Throughout her time at Riggs, petitioner was treated extensively by two doctors whose clinical assessments regarding petitioner's need for treatment ultimately formed part of the record before the plan administrator. See *id.* at 21a-26a, 32a, 33a-35a. One of those doctors, Dr. Sharon Krikorian, also submitted an expert opinion as petitioner's treating physician. *Id.* at 43a-45a.

b. Respondents found that petitioner's admission to the acute inpatient facility and Second Admission to Riggs were medically necessary. *Id.* at 26a. But they denied coverage for all but the first month of her First Admission. *Ibid.* That denial gave rise to this case.

When petitioner arrived at Riggs in January 2013, respondents approved initial coverage based on her doctors' assessment that residential treatment was medically necessary. *Id.* at 27a-28a. Based on conversations with Dr. Krikorian, respondents extended petitioner's coverage through her first three weeks at Riggs. *Id.* at 28a.

Additional time treating petitioner did not change Dr. Krikorian's opinion. Throughout February 2013 (and until petitioner's discharge from Riggs), she continued to advise that petitioner needed the "structure of residential [treatment]" and did not meet the hospital's criteria for "'step down'" to a lower level of care. *Ibid.* Nonetheless, in February 2013, respondents concluded that petitioner's treatment was no longer medically necessary and thus refused to continue coverage. *Id.* at 28a-29a.

Petitioner immediately appealed that denial (while still in residential treatment at Riggs) through her plan's administrative review process. *Id.* at 29a. That process lasted several years. *Id.* at 29a-33a. In addition to the records from petitioner's time at Riggs and respondents' initial decision to deny coverage, the administrative record ultimately included medical opinions from numerous doctors, including Dr. Krikorian. *Id.* at 33a. Several of those

medical opinions supported a finding of medical necessity for the entirety of petitioner's First Admission. See, *e.g.*, *id.* at 43a-47a. Respondents nevertheless upheld their denial of coverage.

2. After exhausting the administrative process, petitioner sued under 29 U.S.C. 1132(a)(1)(B). Because her plan does not alter ERISA's default, all parties agree that she was entitled to have the district court make a *de novo* decision whether her treatment during the First Admission was medically necessary. App., *infra*, 18a.

After an appeal to the First Circuit to determine the proper extent of the administrative record, petitioner moved for an evidentiary hearing before the district court. *Id.* at 9a-10a. She sought to have the competing experts testify and be subject to cross-examination, "as if," in the First Circuit's words, "this were an insurance coverage dispute under state law." *Id.* at 10a. The district court denied petitioner's motion without explanation in a one-sentence docket order. *Id.* at 52a.

The district court then granted respondents' motion for summary judgment. *Id.* at 15a-51a. The court did not, however, find the absence of a "genuine dispute as to any material fact." Fed. R. Civ. P. 56(a). Indeed, the court explicitly stated it was not considering whether there was a genuine fact dispute. App., *infra*, 18a. The court explained that under First Circuit precedent, the usual summary-judgment rules do not apply: "On summary judgment under ERISA, * * * the 'non-moving party is not entitled to the usual inferences in its favor.'" *Ibid.* (quoting *Bard* v. *Bos. Shipping Ass'n*, 471 F.3d 229, 235 (1st Cir. 2006)). Instead, the court may resolve fact disputes, weigh credibility, and draw reasonable inferences. *Ibid.* And "'the factual determination of eligibility for benefits is decided solely on the administrative record.'" *Ibid.*

The court reviewed the evidence that respondents had considered and concluded that petitioner's treatment was not medically necessary. *Id.* at 35a. In reaching that conclusion, the court dismissed opinions from four doctors who opined on the medical necessity of petitioner's treatment. *Id.* at 43a-47a.

The court's evaluation of the medical opinions noted uncertainty about important aspects of the doctors' written opinions. For instance, the court found it "unclear what internal criteria Dr. Krikorian considered in arriving at her conclusions regarding medical necessity, whether they differ from [respondents'] and to what degree." *Id.* at 45a. The court also questioned why Dr. Krikorian and petitioner's other doctors had not prescribed the effective anti-psychotic drug during the First Admission. *Ibid.* And the court wondered whether it could "extend" one doctor's conclusion that the Second Admission was medically necessary "beyond the context he provided." *Id.* at 46a. Nonetheless, as noted, the court denied petitioner's request for an evidentiary hearing at which such questions could have been explored. *Id.* at 52a.

3. a. The First Circuit affirmed. *Id.* at 1a-14a. The court first agreed with the district court about the special summary-judgment standard in ERISA cases. "[A] summary judgment motion in a lawsuit contesting the denial of benefits under ERISA 'is simply a vehicle for teeing up the case for decision on the administrative record.'" *Id.* at 4a-5a (citation omitted). Accordingly, "'the burdens and presumptions normally attendant to summary judgment practice do not apply.'" *Id.* at 4a (citation omitted).

The court admitted that this was "not an easy [case]" (*id.* at 14a), but found petitioner's arguments "unavailing given the clear error standard of review" (*id.* at 8a). Although this was summary judgment, the court accepted that the district court "agreed more with [respondent]'s

experts than with [petitioner's]." *Id.* at 9a. The district court did not "clearly err[] in making the inferences that it did" to resolve the numerous fact disputes. *Id.* at 8a. And while the panel acknowledged contrary evidence that could have led a different factfinder to a different conclusion, "it was not clear error for the district court to conclude that * * * [petitioner's] continued stay at Riggs was not medically necessary." *Id.* at 8a-9a.

b. The First Circuit next agreed with the district court confining its review to the record before the administrator. It held that "the record is limited to the record" before the administrative decisionmaker "absent some very good reason to do otherwise." *Id.* at 10a. Potential "very good reason[s]" were procedural challenges—claims that the "process of decision-making was unlawful or that the administrator exhibited a conflict of interest" or "that materials were improperly omitted from the [administrative] record." *Ibid.*

The First Circuit's justification for this restrictive rule borrowed from administrative-law concepts. See *ibid.* Considering "extra-administrative record evidence going to the substance of the decision" under review "would offend interests in finality and exhaustion of administrative procedures." *Orndorf*, 404 F.3d at 519.

The court made clear that it had "long ago rejected" the idea that ERISA benefit claims should be adjudicated like other claims in federal court. App., *infra*, 10a (citing *Orndorf*, 404 F.3d at 519). *Orndorf* had explained that "[r]eview of the ultimate conclusion of whether the evidence supports the [administrator's] finding * * * does not itself warrant introduction of new evidence about historical facts." 404 F.3d at 518. It held that "new evidence [that] directly concerned the question of [the plaintiff's] disability" was thus inadmissible. *Id.* at 519.

Following *Orndorf*'s reasoning, the First Circuit here distinguished between "an insurance coverage dispute," where it agreed evidence would be allowed, and this "judicial review of an administrator's benefit decision under ERISA." App., *infra*, 10a. To that end, the court found the distinction between the *de novo* and arbitrary-and-capricious standards irrelevant. *Id.* at 11a; see *Orndorf*, 404 F.3d at 519.

Petitioner's request for a hearing to question the doctors about their conflicting opinions was therefore out of the question. "[J]udicial review does not 'warrant calling as witnesses those persons whose opinions and diagnosis or expert testimony and reports are in the administrative record.'" App., *infra*, 10a (quoting *Orndorf*, 404 F.3d at 519).

REASONS FOR GRANTING THE PETITION

I. THE FIRST QUESTION PRESENTED WARRANTS FURTHER REVIEW

Despite Rule 56's plain text, the circuits are starkly divided over whether a district court may grant summary judgment on a Section 1132(a)(1)(B) claim in the face of material fact disputes. The First Circuit's holding that Rule 56 does not apply to ERISA benefits claims warrants further review.

A. There Is An Acknowledged And Intractable Circuit Split Over The First Question

The First Circuit held that "'the burdens and presumptions normally attendant to summary judgment practice do not apply.'" App., *infra*, 4a (citation omitted). Instead, contrary to Rule 56(a), the district court should weigh the evidence and resolve factual conflicts. *Id.* at 4a-5a. That holding squarely conflicts with ten circuits that apply the usual Rule 56 standard to ERISA benefits claims.

1. The Seventh Circuit expressly rejected the First Circuit's "potentially misleading standard for 'summary judgment,'" which "treat[s] summary judgment as summary in name only." *Patton*, 480 F.3d at 484 n.3 (citing *Orndorf*, 404 F.3d at 517). "[I]nstead," the Seventh Circuit "appl[ies] the normal rule: *de novo* review, with judgment appropriate if there is no genuine issue of material fact." *Ibid.*; see, *e.g.*, *Krolnik*, 570 F.3d at 844.

The other circuits (aside from the Sixth) agree, uniformly holding that summary judgment must be denied when genuine fact disputes remain.

The Second Circuit's approach is illustrative: "a district court may not grant a motion for summary judgment if the record reveals a dispute over an issue of material fact." *O'Hara* v. *Nat'l Union Fire Ins. Co.*, 642 F.3d 110, 117 (2d Cir. 2011). The district court there thus erred when it "'weigh[ed] competing physician opinions'" and made "'findings of fact'" despite "evidence that would otherwise create a genuine issue of fact." *Ibid.*; see, *e.g.*, *Tretola* v. *First Unum Life Ins. Co.*, No. 13-Civ.-231(PAE), 2015 WL 509288, at *23 (S.D.N.Y. Feb. 6, 2015) (noting "the Second Circuit's teaching that it is inappropriate for a court to grant summary judgment where the resolution of an ERISA benefits dispute entails adopting one medical expert's opinion over another's") (citing *Napoli* v. *First Unum Life Ins. Co.*, 78 F. App'x 787, 789 (2d Cir. 2003)). Yet that exact error is what the First Circuit approved. App., *infra*, 4a-5a.

The Fourth Circuit has also acknowledged the split in authority on this issue, and although it has noted some "reservations" in following Rule 56 for ERISA benefits claims, it too has adhered to "the normal summary judgment standard" in such cases. *Phelps* v. *C.T. Enters., Inc.*, 394 F.3d 213, 218 (4th Cir. 2005); see also, *e.g.*, *Mantica* v.

Unum Life Ins. Co. of Am., No. CV RDB-18-0632, 2019 WL 1129438, at *7 (D. Md. Mar. 12, 2019).

The remaining circuits likewise apply the summary judgment standard that Rule 56 demands. See, *e.g.*, *Reed* v. *CITIGROUP, Inc.*, 658 F. App'x 112, 113, 117 (3d Cir. 2016) (holding that "[a]s these are factually intense inquiries, we conclude that summary judgment was not appropriate"); *Rhorer* v. *Raytheon Eng'rs & Constructors, Inc.*, 181 F.3d 634, 644 (5th Cir. 1999) (reversing grant of summary judgment because "two factors, when viewed together in a light most favorable to Rhorer, do give rise to a genuine issue of material fact"); *Silva* v. *Metro. Life Ins. Co.*, 762 F.3d 711, 718-719 (8th Cir. 2014) (reversing grant of summary judgment due to "outstanding questions of material fact"); *Kearney* v. *Standard Ins. Co.*, 175 F.3d 1084, 1094 (9th Cir. 1999) (en banc) ("Because the record establishes a genuine issue of fact as to whether Mr. Kearney was disabled under the terms of the policy, we must reverse the summary judgment."); *Niles* v. *Am. Airlines, Inc.*, 269 F. App'x 827, 834 (10th Cir. 2008) (vacating summary judgment because the "district court should instead have examined all the medical evidence * * * and determined whether that evidence created a genuine issue of material fact concerning whether Ms. Niles was disabled"); *Kirwan* v. *Marriott Corp.*, 10 F.3d 784, 790 (11th Cir. 1994) (district court erroneously grants summary judgment when the "evidence presents a genuine issue of material fact"); *Fitts* v. *Unum Life Ins. Co. of Am.*, 520 F.3d 499, 502 (D.C. Cir. 2008) (vacating summary judgment "[b]ecause there was a genuine dispute about the possible causes of bipolar disorder").

The First Circuit's decision to discard the Rule 56 standard thus contradicts the rule in ten other circuits, all of which apply the standard prescribed by the Federal Rules of Civil Procedure.

2. By contrast, the Sixth Circuit has adopted a position similar to the First Circuit's, although it is candid about eschewing Rule 56. According to the Sixth Circuit, "the concept of summary judgment is inapposite to the adjudication of an ERISA action." *Wilkins* v. *Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 619 (6th Cir. 1998). That is because, as discussed *infra* pp. 28-29, the Sixth Circuit "confin[es] the district court's *de novo* review to the evidence contained in the administrative record." 150 F.3d at 618. "Because this court's precedents preclude an ERISA action from being heard by the district court as a regular bench trial, it makes little sense to deal with such an action by engaging a procedure designed solely to determine 'whether there is a genuine issue for trial.'" *Id.* at 619 (citation omitted). As a result, the Sixth Circuit created "a specially fashioned rule" under which the district court "render[s] findings of fact and conclusions of law" "based solely upon the administrative record." *Id.* at 618, 619.

3. The decisions of the First and Sixth Circuits therefore squarely conflict with the decisions of ten other circuits. This binary question is a perfect candidate for plenary review: either the district court asks whether "there is no genuine dispute as to any material fact" (Fed. R. Civ. P. 56(a)) or, as the First Circuit commands, the court employs an ERISA-specific rule to weigh the evidence itself. That question should have a single answer for every circuit.

B. The First Question Frequently Recurs And Is Extremely Important

Respondents will be unable to dispute that this circuit split exists or that it frequently recurs—the question arises whenever one party moves for summary judgment and material facts conflict.

Nor should the issue's importance be doubted. For one thing, allowing two circuits to apply the Federal Rules differently from the other circuits defeats the purpose of a uniform set of judicial procedures. Cf. Fed. R. Civ. P. 1. Even were the First Circuit correct that ERISA summary judgment "is akin to judgment following a bench trial" (App., *infra*, 5a), then the solution would be to deny summary judgment and have the parties proceed *under bench-trial procedures* (*e.g.*, Rules 43 and 52), not modify summary judgment. And either way, the circuits' distinct approaches interfere with ERISA's overriding interest in uniformity.

Moreover, courts and commentators recognize important practical differences between rendering decision at summary judgment or after a Rule 52 bench trial. Under Rule 52, the "district judge will be asking a different question as he reads the evidence, not whether there is a genuine issue of material fact, but instead whether" the plaintiff is entitled to benefits under the plan's terms. *Kearney*, 175 F.3d at 1095. "The process of finding the facts 'specially,' as [Rule 52] requires, sometimes leads a judge to a different conclusion from the one he would reach on a more holistic approach." *Ibid.* Indeed, that requirement is "possibly" the "most important" aspect of Rule 52, designed "to evoke care on the part of the trial judge in ascertaining and applying the facts." 9C Arthur R. Miller, *Fed. Practice & Procedure* § 2571 (3d ed.).

In any event, critically for this case and many like it, the difference between summary judgment and a bench trial implicates the second question presented here—whether district courts can consider additional evidence. The First Circuit thinks the district court can resolve fact disputes on summary judgment because it conceives of the motion as "'simply a vehicle for teeing up the case for decision *on the administrative record*.'" App., *infra*, 4a-5a

(citation omitted) (emphasis added); see *Wilkins*, 150 F.3d at 618-619. It is only at a bench trial where evidence must be taken. See *Krolnik*, 570 F.3d at 843-844. Accordingly, the First Circuit's atextual, "far-reaching approach" to summary judgment (*Patton*, 480 F.3d at 484 n.3) wrongly uses summary judgment "to deprive a litigant of a full trial of genuine fact issues." 10A Mary Kay Kane, *Fed. Practice & Procedure* § 2712 (4th ed.). And as explained *infra* Part II, whether a litigant can introduce additional evidence is of surpassing importance to the proper application of ERISA.

C. The First Circuit's Special ERISA Summary-Judgment Rule Is Wrong

The First Circuit erroneously affirmed summary judgment despite an acknowledged fact dispute. App., *infra*, 4a-5a. That error is straightforward. "[A]t the summary judgment stage the judge's function is not himself to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson* v. *Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986). And this Court has held that Section 1132(a)(1)(B) claims should proceed like other claims. *E.g.*, *Krolnik*, 570 F.3d at 843 (citing *Firestone*, 489 U.S. at 112-113). Accordingly, as in any other case, when "a paper record contains a material dispute, a trial is essential." *Id.* at 844.

There is no basis for departing from that usual application of Rule 56. Even when a paper record does supply the only evidence, Rule 56 proceedings and bench trials serve different purposes. *Supra* Part I.B. So even in those cases, the correct approach is to faithfully apply Rule 56 and then Rule 52, not modify Rule 56 to distort the proper inquiries.

D. This Is An Ideal Vehicle To Resolve The Split

This case is a perfect vehicle to resolve this question. The First Circuit effectively conceded that the difference

between a regular application of Rule 56 and its special application was dispositive. The case was "not an easy one." App., *infra*, 14a. The physicians' reports supported both sides, and the First Circuit affirmed only because it found acceptable that "the district court implicitly agreed more with Harvard Pilgrim's experts than with Doe's." App., *infra*, 9a. Of course, agreeing with one side's experts over another's would have warranted reversal under Rule 56. See, *e.g.*, *O'Hara*, 642 F.3d at 117.

II. THE SECOND QUESTION PRESENTED WARRANTS FURTHER REVIEW

The circuit courts are hopelessly divided over when a district court may allow parties to supplement the record on benefits claims adjudicated under *Firestone*'s *de novo* standard. This conflict has been percolating for almost two decades, and nearly every circuit has weighed in.

Whereas the First and Sixth Circuits confine the record to that before the administrator, the Third, Seventh, and Eleventh freely allow new evidence, and still others permit additional evidence in certain circumstances. That wide divergence in approaches is intolerable for a statute like ERISA that presents a particular need for nationwide uniformity. It is past time for a nationwide answer.

A. There Is An Acknowledged And Intractable Circuit Split Over The Second Question

According to the First Circuit, unless the plaintiff has challenged the procedures used by the plan administrator, district courts must confine themselves to the record before the administrator. App., *infra*, 10a-11a. They cannot consider other evidence, and they are barred from hearing the live testimony that bench trials generally permit. *Ibid.*; see *Orndorf*, 404 F.3d at 518-519; *Kamerer* v. *Unum Life Ins. Co. of Am.*, 251 F. Supp. 3d 349, 353 (D. Mass. 2017) ("[F]or a plaintiff to reach outside the administrative record relating to the specific decision they must

have a meaningful challenge to the 'procedure used.'") (quoting *Orndorf*, 404 F.3d at 520); *Ortega-Candelaria* v. *Orthobiologics, LLC*, No. 08-2382, 2012 WL 1982401, at *2 (D.P.R. June 1, 2012); *Morales-Cintron* v. *Great Am. Life Ins. Co. of P.R.*, No. 07-1595, 2008 WL 11502467, at *1 & n.2 (D.P.R. Feb. 22, 2008); *Brilmyer* v. *Univ. of Chicago*, 431 F. Supp. 2d 154, 159 (D. Mass. 2006).

That rigid approach puts the First Circuit on the wrong side of a lopsided circuit split.

1. Full discretion to consider evidence (CA3, 7, 11). The Third, Seventh, and Eleventh Circuits treat *de novo* benefits claims just like any other dispute, leaving the consideration of evidence to the sound discretion of the district court.

a. In the Third Circuit, "a district court exercising *de novo* review over an ERISA determination between beneficiary claimants is not limited to the evidence before the [plan] Administrator." *Luby* v. *Teamsters Health, Welfare, & Pension Trust Funds*, 944 F.2d 1176, 1184-1185 (3d Cir. 1991); see *Viera* v. *Life Ins. Co. of N. Am.*, 642 F.3d 407, 418 (3d Cir. 2011); *Heasley* v. *Belden & Blake Corp.*, 2 F.3d 1249, 1262 n.14 (3d Cir. 1993); see also, *e.g.*, *Ariana M.*, 884 F.3d at 256 (Fifth Circuit acknowledging *Luby*'s different approach); *Liston* v. *Unum Corp. Officer Severance Plan*, 330 F.3d 19, 24 (1st Cir. 2003) (characterizing the Third Circuit as "not providing any qualifications on when additional evidence may be considered"). The court in *Luby* noted that limiting evidence "was appropriate" under deferential review. 944 F.2d at 1184. But such a limit "is 'contrary to the concept of *de novo* review.'" *Ibid.* (quoting *Moon* v. *Am. Home Assurance Co.*, 888 F.2d 86, 89 (11th Cir. 1989)). The "ordinar[y]" meaning of *de novo* is that "'the court's inquiry is not limited to or con-

stricted by the * * * record.'" *Ibid.* (citation omitted) (emphasis removed). The court thus rejected decisions imposing that restriction. *Id.* at 1184-1185 & n.8.

District-court decisions applying *Luby* show how petitioner's case would have come out had she sued in the Third Circuit. For instance, in *Sallavanti* v. *Unum Life Ins. Co. of Am.*, 980 F. Supp. 2d 664 (M.D. Pa. 2013), like here, "[p]erhaps the most important question" was "whether [the plaintiff's] doctors' findings and conclusions should be accepted over those of [the insurer's] doctors." *Id.* at 670. The court rejected the insurer's effort to limit the record. It explained that *Luby* "makes clear" that "such limitations are purely discretionary. Nowhere does the court in *Luby* say that a district court must, or even should, limit its review to what is contained in a fully developed record." *Id.* at 666. Accordingly, the factual disputes were "best reserved for trial where [plaintiff] and all relevant doctors' credibility can be determined based on their qualifications, testimony, and demeanor." *Id.* at 670.

Other decisions from within the Third Circuit hold similarly. See, *e.g.*, *Dwyer* v. *Unum Life Ins. Co. of Am.*, 470 F. Supp. 3d 434, 439 (E.D. Pa. 2020) (holding that there was no "basis for Unum being able to prevent Plaintiff from deposing the medical consultants, as their findings regarding Plaintiff's non-disability go to the heart of the matter"); *Viera* v. *Life Ins. Co. of N. Am.*, No. 09-3574, 2012 WL 13206544, at *1 n.1 (E.D. Pa. June 5, 2012) ("allow[ing] cross-examination of both of those experts"); *Bair* v. *Life Ins. Co. of N. Am.*, No. 09-cv-00549, 2011 WL 4860006, at *4 (E.D. Pa. Oct. 13, 2011); *Briglia* v. *Horizon*

Healthcare Servs., Inc., No. 03-6033-NLH-JS, 2010 WL 4226512, at *1, *4, *6 (D.N.J. Oct. 21, 2010).[1]

By contrast, in the First Circuit, examining the experts has been "long" rejected. App., *infra*, 10a (citing *Orndorf*, 404 F.3d at 519).

b. Like *Luby*, the Eleventh Circuit held that "a district court conducting a *de novo* review of an Administrator's benefits determination is not limited to the facts available to the Administrator at the time of the determination." *Kirwan*, 10 F.3d at 789; see *id.* at 789 n.31 (noting circuit split and approving *Luby*); *Moon*, 888 F.2d at 89; *DeFelice* v. *Am. Int'l Life Assurance Co. of N.Y.*, 112 F.3d 61, 65 (2d Cir. 1997) (citing *Moon* and stating that "the Eleventh Circuit seems comfortable allowing district courts to rely upon entirely new evidence without restriction"); *Hall*, 300 F.3d at 1201. The Eleventh Circuit reasoned that "the concept of a de novo review" forecloses an evidentiary bar. *Moon*, 888 F.2d at 89. Moreover, forbidding extra evidence would contravene ERISA's purpose by "'afford[ing] less protection to employees and their beneficiaries than [they enjoyed] before ERISA was enacted.'" *Ibid.* (quoting *Firestone*, 489 U.S. at 114) (second alteration in original).

Following *Kirwan* and *Moon*, Eleventh Circuit district courts regularly expand the record beyond what the plan administrator considered. See, *e.g.*, *Edwards* v. *Blue Cross & Blue Shield of Ga., Inc.*, No. 1:14-CV-2626-CC, 2015 WL 12856454, at *3 (N.D. Ga. Sept. 30, 2015) ("It is well-established in this circuit that courts may consider matters outside of the administrative record when the

[1] Underscoring the confusion among the courts, some circuits misunderstand the Third Circuit as applying a somewhat more restrictive standard. See *Patton*, 480 F.3d at 491 (citing *Luby*); *Hall*, 300 F.3d at 1201 (citing *Luby*).

standard of review is *de novo*."); *Anderson* v. *Unum Life Ins. Co. of Am.*, 414 F. Supp. 2d 1079, 1100-1101 & n.18 (M.D. Ala. 2006) (considering doctor's deposition testimony); cf. *Edgar* v. *Disability Reinsurance Mgmt. Servs., Inc.*, 741 F. Supp. 2d 1268, 1271 (N.D. Ala. 2010). Those requests, however, would fail in the First Circuit.

c. Similarly, the Seventh Circuit instructs district courts to "freely allow the parties to introduce relevant extra-record evidence and seek appropriate discovery." *Dorris*, 949 F.3d at 304; see *id.* at 304 n.1 (recognizing split). In exercising their discretion, district courts should consider "[n]umerous factors," "[t]he most important" of which is "whether the evidence is 'necessary' to an 'informed and independent judgment' on the parties' claims and defenses." *Patton*, 480 F.3d at 490-491; see, *e.g.*, *Estate of Blanco* v. *Prudential Ins. Co. of Am.*, 606 F.3d 399, 402 (7th Cir. 2010); *Casey* v. *Uddeholm Corp.*, 32 F.3d 1094, 1099 (7th Cir. 1994).

Under that rubric, however, the Seventh Circuit has emphasized that "litigation under ERISA by plan participants seeking benefits should be conducted just like contract litigation, for the plan and any insurance policy are contracts." *Krolnik*, 570 F.3d at 843 (citing *Firestone*, 489 U.S. at 112-113); see, *e.g.*, *Borich* v. *Life Ins. Co. of N. Am.*, No. 12-C-734, 2013 WL 1788478, at *5 (N.D. Ill. Apr. 25, 2013); *Shepherd* v. *Life Ins. Co. of N. Am.*, No. 11-C-3846, 2012 WL 379775, at *1 (N.D. Ill. Feb. 3, 2012).

Krolnik best explains what this means for the record in *de novo* cases. In ordinary insurance litigation, "the federal judge won't ask what evidence the insurer considered," and the "judge would not dream of forbidding the parties to take discovery." *Krolnik*, 570 F.3d at 843. Rather, "[e]vidence is essential if the court is to fulfill its fact-finding function. Just so in ERISA litigation." *Ibid.*

By the same token, if the "paper record contains a material dispute, a trial is essential." *Id.* at 844. And at trial, the plaintiff should be "free" to "cross-examine the physicians who produced the reports that underlie [the plan administrator's] decision." *Ibid.*; see, *e.g.*, *Gavin* v. *Life Ins. Co. of N. Am.*, No. 12-C-6178, 2013 WL 2242230, at *2 (N.D. Ill. May 21, 2013); *Gingras* v. *Prudential Ins. Co. of Am.*, No. 06-C-2195, 2007 WL 1052500, at *7 (N.D. Ill. Apr. 4, 2007) (allowing "testimony from the treating and consulting physicians" because "resolution of this matter hinges on the credibility of the parties' witnesses"); *Wonsowski* v. *United of Omaha Life Ins. Co.*, No. 15-C-3795, 2016 WL 3088141, at *1 & n.2 (N.D. Ill. June 2, 2016).

The First Circuit, by contrast, invoked the same insurance-litigation analogy to reach the opposite conclusion. It criticized petitioner for asking that "various experts testify and be subject to cross-examination, as if this were an insurance coverage dispute under state law, rather than judicial review of an administrator's benefit decision under ERISA." App., *infra*, 10a. In the First Circuit, "judicial review does not 'warrant calling as witnesses those persons whose opinions and diagnosis or expert testimony and reports are in the administrative record.'" *Ibid.* (quoting *Orndorf*, 404 F.3d at 519). That holding is directly at odds with the Seventh Circuit's long-held position.[2]

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[2] Certain Seventh Circuit decisions cite cases in what petitioner has characterized as the "limited discretion" group. *E.g.*, *Patton*, 480 F.3d at 491; see *infra* pp. 25-27. But at least since *Krolnik*, the Seventh Circuit has instructed district courts to treat ERISA claims like any other dispute, giving district courts broad license to consider additional evidence. See *Dorris*, 949 F.3d at 304; *Shepherd*, 2012 WL 379775, at *1. Whatever category the Seventh Circuit falls in, the important point is that its approach differs starkly from the First Circuit's.

2. Limited discretion (CA2, 4, 8, 9, 10). Another group of circuits occupies a middle ground between the First and Sixth Circuits and the Third, Seventh, and Eleventh Circuits. These courts allow supplementary evidence, but limit the district court's discretion by requiring specific findings to justify the new evidence. Even within this cohort, the approaches vary. In each of these circuits, however, the district court would have had discretion to consider the testimony petitioner requested here.

a. The Fourth Circuit articulated the prevailing limited-discretion approach in *Quesinberry* v. *Life Insurance Co. of N. Am.*, 987 F.2d 1017, 1021-1027 (4th Cir. 1993). The court described other circuits' "divergent views" on "the proper scope of *de novo* review." *Id.* at 1022-1023. It contrasted the more lenient rules of the Third and Eleventh Circuits (*id.* at 1024-1025 (discussing *Luby* and *Moon*)) with the Sixth Circuit's cramped approach, which "strictly limited the scope of the district court's review to the evidence that was presented to the plan administrator," *id.* at 1023 (citing *Perry* v. *Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990)). It also noted the distinct reasons underlying other circuits' decisions: promoting and protecting employees' interests versus "prompt" claim resolution. *Id.* at 1025.

Attempting to balance those goals, the Fourth Circuit adopted a "limited discretionary approach," where the district court has discretion to permit additional evidence "only when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision." *Ibid.*; see *id.* at 1026-1027. Its non-exclusive list of appropriate circumstances included "claims that require consideration of complex medical questions or issues regarding the credibility of medi-

cal experts" and "the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts." *Id.* at 1027.

Applying that test, the Fourth Circuit affirmed the district court's inclusion of "live expert medical testimony regarding the complex issue of Mrs. Quesinberry's cause of death," *i.e.*, exactly the type of evidence that the First Circuit prohibited here. *Ibid.* And the court further stressed the advantages of live testimony that escaped the First Circuit: "Such testimony could facilitate the understanding of complex medical terminology and causation through an exchange of questions and answers between the experts, counsel, and the court." *Ibid.* The First Circuit's decision is thus irreconcilable with *Quesinberry*.

b. The Ninth Circuit "follow[ed]" *Quesinberry*, holding "that the district court had discretion to allow evidence that was not before the plan administrator 'only when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review.'" *Kearney*, 175 F.3d at 1090-1091 (quoting *Mongeluzo* v. *Baxter Travenol Disability Ben. Plan*, 46 F.3d 938, 944 (9th Cir. 1995)). Contrary to the First Circuit, therefore, the Ninth Circuit has approved the admission of additional evidence and testimony to resolve medical and credibility disputes. See, *e.g.*, *Feibusch* v. *Integrated Device Tech., Inc. Emp. Ben. Plan*, 463 F.3d 880, 886 (9th Cir. 2006); *Thomas* v. *Oregon Fruit Prods. Co.*, 228 F.3d 991, 997 (9th Cir. 2000).

c. The Eighth Circuit similarly requires "good cause" to expand the record, and would have permitted the evidence petitioner sought to introduce here. *Donatelli* v. *Home Ins. Co.*, 992 F.2d 763, 765 (8th Cir. 1993). "If it is necessary for adequate de novo review of the fiduciary's decision, the district court may allow the parties to intro-

duce evidence in addition to that presented to the fiduciary." *Ibid.* (citing *Quesinberry* and *Luby*). Under that rule, it affirmed the district court's inclusion of "additional expert testimony" regarding whether the decedent was sane. *Ibid.*; see also, *e.g.*, *Johnson* v. *Wellmark of S. Dak., Inc.*, 441 F. Supp. 3d 780, 794-797 (D.S.D. 2020).

d. The Tenth Circuit, after canvassing other circuits' conflicting positions, expressly adopted *Quesinberry*'s approach in *Hall*, 300 F.3d at 1201-1202. See, *e.g.*, *Rasenack* ex rel. *Tribolet* v. *AIG Life Ins. Co.*, 585 F.3d 1311, 1327 (10th Cir. 2009).

e. Finally, the Second Circuit permits a district court to expand the record if it "finds good cause to consider additional evidence." *DeFelice*, 112 F.3d at 66-67. While that circuit has not defined the full scope of its "good cause" standard, district courts regularly supplement the record to resolve disputed fact issues. See, *e.g.*, *Paese* v. *Hartford Life & Accident Ins. Co.*, 449 F.3d 435, 441 (2d Cir. 2006); *Napoli*, 78 F. App'x at 790; *Tretola*, 2015 WL 509288, at *26-*27, *30 (given disputed material facts, setting trial with witnesses); *Rodriguez* v. *McGraw-Hill Cos.*, 297 F. Supp. 2d 676, 679 (S.D.N.Y. 2004) (setting bench trial with doctors' testimony "for clarifying the ambiguities in some of the testimony given below, as well as for assessing the credibility of the competing experts").

Again, under the First Circuit's rule, those courts would have been confined to the record before the administrator despite the conflicting medical evidence.

3. Idiosyncratic Fifth Circuit approach. Exacerbating the confusion among the circuits, the Fifth Circuit has staked out a unique position. In a recent en banc decision, the court noted that the circuits "take a variety of positions on whether *de novo* review allows a party to expand the record beyond what was before the plan administra-

tor." *Ariana M.*, 884 F.3d at 256. The court decided to adhere to its precedent, which generally confines district courts to the administrator's record "even in the face of disputed facts." *Ibid.* (citing *Vega* v. *Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 299 (5th Cir. 1999) (en banc), overruled on other grounds by *Glenn*, 554 U.S. 105). The court allows "very limited" exceptions: "to explain how the administrator has interpreted the plan's terms in previous instances" and "to assist in the understanding of medical terminology related to a benefits claim." *Ibid.* No other circuit has adopted the Fifth Circuit's approach.

4. Procedural challenges only (CA1, 6). The lone circuit to limit the record like the First Circuit is the Sixth Circuit. "Unlike some courts, we have held that a court conducting a de novo review in an ERISA case is confined to evidence that was included in the record upon which the administrator based its decision." *Wulf* v. *Quantum Chem. Corp.*, 26 F.3d 1368, 1376 (6th Cir. 1994) (citing *Perry*, 900 F.2d at 966); see *Wilkins*, 150 F.3d at 615. That court reasoned that district courts should not "function as substitute plan administrators." *Perry*, 900 F.2d at 966 (rejecting Eleventh Circuit's "contrary view" in *Moon*); see, *e.g.*, *Weiner* v. *Aetna Health Plans of Ohio, Inc.*, 149 F.3d 1185, at *2-*3 (6th Cir. 1998) (unpublished) (district court erred by considering deposition testimony); *Cornish* v. *U.S. Life Ins. Co. of City of N.Y.*, No. 3:06-CV-344-DW, 2009 WL 3231351, at *5, *13 (W.D. Ky. Sept. 30, 2009) (recognizing split and declining to consider new evidence that would "call into question the accuracy" of the administrator's decision on the dispute's "most important question"); *Mitchell* v. *First Unum Life Ins. Co.*, 65 F. Supp. 2d 686, 693 (S.D. Ohio 1998). The Sixth Circuit's only exception is for "a procedural challenge to a plan administrator's decision alleging a lack of due process or

bias." *Lipker* v. *AK Steel Corp.*, 698 F.3d 923, 929 n.2 (6th Cir. 2012).

* * *

This conflict is thus undeniable, and the arguments on each side are well ventilated. While the First and Sixth Circuits prohibit new evidence absent a challenge to the plan's procedures, the Third, Seventh, and Eleventh freely permit new evidence, five other circuits allow new evidence on specific findings by the district court, and the Fifth Circuit has rejected all those positions in favor of idiosyncratic exceptions.

That split—involving so many courts and different approaches—will never resolve itself without this Court's involvement. Certiorari is plainly warranted.

B. The Second Question Frequently Recurs And Is Extremely Important

The proper scope of the record before the district court arises constantly in benefits litigation under the *de novo* standard, as reflected by the numerous decisions in the preceding section. Settling that issue is urgently needed.

First, uniformity is particularly important in the ERISA context. See, *e.g.*, *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 379 (2002). The scope of the record should not vary based on whether the plaintiff sued in Massachusetts or Pennsylvania.[3]

[3] Although plans might be able to avoid this problem by investing administrators with discretion, that is a poor solution. The weighty question whether to give administrators discretion should not be influenced by the circuits' inability to agree on a uniform rule of law. Moreover, when making that decision, a plan should know the precise consequences involved—but those consequences are uncertain while this circuit conflict persists.

Second, courts like the First and Sixth Circuits that impose restrictions on new evidence are impeding participants and beneficiaries from vindicating their rights. *E.g.*, *Moon*, 888 F.2d at 89 (quoting *Firestone*, 489 U.S. at 114). "Evidence is essential if the court is to fulfill its fact-finding function." *Krolnik*, 570 F.3d at 843. And where "a paper record contains a material dispute, a trial is essential" so that the plaintiff can "cross-examine the physicians who produced the reports that underlie [the administrator's] decision." *Id.* at 844. That opportunity is especially crucial in cases like this one, where the plan's procedures did not grant a hearing. Yet in the view of the First Circuit, trial is forbidden. The participant or beneficiary is stuck with the record before the administrator, and she *never* gets a live hearing to challenge the opposing experts.

Petitioner's claim highlights this point. The expert medical evidence was conflicting, with the district court explicitly noting uncertainties in their reports. *Supra* p. 11. And as the First Circuit acknowledged, in a non-ERISA case petitioner would have been able to cross-examine respondents' experts. See App., *infra*, 10a. But because this was an ERISA claim, the First Circuit denied her the usual methods of exposing flaws in respondents' evidence. That turns ERISA on its head. Congress aimed to make it *easier*, not harder, for claimants to protect their benefits. *E.g.*, *Firestone*, 489 U.S. at 113-114; 29 U.S.C. 1001.

Third, the array of exceptions developed by some of the circuits makes plans and plaintiffs incur needless costs litigating whether those exceptions apply or even exist. Cf. *Glenn*, 554 U.S. at 116-117 (discouraging "special procedural rules [that] would create further complexity, adding time and expense to a process that may already be too costly for many of those who seek redress"). This Court

should grant review to end the uncertainty about the scope of the record.

C. The First Circuit's Special ERISA Evidentiary Rule Is Wrong

It should be unsurprising that only one other circuit views this question like the First Circuit. The First Circuit's rule barring evidence outside the plan administrator's record is wrong.

In *Firestone*, this "Court repeatedly wrote that litigation under ERISA by plan participants seeking benefits should be conducted just like contract litigation, for the plan and any insurance policy are contracts." *Krolnik*, 570 F.3d at 843 (citing *Firestone*, 489 U.S. at 112-113). And when "a paper record contains a material dispute" during ordinary contract litigation, the plaintiff "would be free to offer medical evidence of his own and cross-examine the physicians who produced the [underlying] reports." *Id.* at 844. Should a party's litigation tactics impose undue burden or expense, the Federal Rules of Civil Procedure and Federal Rules of Evidence already equip district courts to act. Cf. *id.* at 843. There is no need for the First Circuit's special rule.

The First Circuit offered no persuasive reason for defying *Firestone*'s instruction. In the first place, nothing in ERISA's text imposes special evidentiary limits. Cf. *Kappos* v. *Hyatt*, 566 U.S. 431, 437 (2012). The First Circuit invoked "interests in finality and exhaustion of administrative procedures." *Orndorf*, 404 F.3d at 519. But concerns about administrative exhaustion are irrelevant where the administrative body's "process is complete." *Kappos*, 566 U.S. at 439.

Relatedly, the Sixth Circuit wanted to resolve disputes "inexpensively and expeditiously." *Perry*, 900 F.2d at 967. But cost avoidance does not justify deviating from federal courts' normal adjudicative procedures. See *Firestone*,

489 U.S. at 115 ("the threat of increased litigation is not sufficient to outweigh the reasons for a *de novo* standard"). Critically, giving participants and beneficiaries less protection is an impermissible tradeoff for a quick answer. Cf. *Firestone*, 489 U.S. at 114-115.

At bottom, the First Circuit fundamentally misconstrued the judicial function in *de novo* cases. *Firestone* does not require "'review' of any kind," but rather "an independent *decision*." *Krolnik*, 570 F.3d at 843 (emphasis in original). Yet the First Circuit essentially treats the district court as itself an appellate tribunal sitting over an administrative body. Under a correct conception of the court's role, the proper course of proceedings is plain: "the court takes evidence (if there is a dispute about a material fact) and makes an independent decision about how the language of the [plan] applies to those facts." *Krolnik*, 570 F.3d at 843; cf. *Kappos*, 566 U.S. at 438 (court's ability to consider new evidence goes hand-in-hand with *de novo* review). The First Circuit's failure to follow that procedure warrants review.

D. This Is An Ideal Vehicle To Resolve The Split

This is an ideal vehicle for resolving this issue. It presents the paradigmatic scenario that has divided the courts: a request to present evidence to resolve conflicting expert medical evidence about petitioner's health and the threshold for relief under the plan's terms. And the First Circuit affirmed the denial of petitioner's request based solely on its rule restricting the record. There was no exercise of discretion by the district court. Rather, the First

Circuit categorically prohibited the testimony as inconsistent with its conception of *de novo* "review." App., *infra*, 10a-11a; cf. *Orndorf*, 404 F.3d at 518-519.[4]

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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[4] Respondents wrongly argued waiver below. App., *infra*, 9a n.2. The First Circuit addressed petitioner's argument on its merits. *Id.* at 9a-11a.