UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

ESTATE OF MICHAEL GIFFORD,
by its special administrator, SUZANNE GIFFORD,
Plaintiff,

v. **Case No. 22-C-0221**

OPERATING ENGINEERS 139 HEALTH BENEFIT FUND,
Defendant.

DECISION AND ORDER

Michael Gifford suffered a stoke and was admitted to a hospital, where he received emergency treatment. During treatment for the stroke, hospital staff discovered what they thought was a small brain aneurysm. Over the next several days, Gifford received treatment for the aneurysm from a neurosurgeon who was not in the PPO network of Gifford's health plan. That treatment culminated in a brain surgery from which Gifford never regained consciousness. He died a few days later.

Gifford's health plan, the Operating Engineers 139 Health Benefit Fund (the "Plan"), covers out-of-network services only in the event of an emergency. After a claim for payment for the neurosurgeon's services was made, the Plan determined that Gifford's aneurysm did not require emergency treatment and that the neurosurgeon's involvement was not medically necessary. It denied the claim.

Gifford's estate (the "Estate") brings this action under the Employee Retirement Income Security Act of 1974 ("ERISA") against the Plan. Primarily, the estate brings a claim for denial of benefits under 29 U.S.C. § 1132(a)(1)(B). However, it also brings a

claim for appropriate equitable relief under 29 U.S.C. § 1132(a)(3), in which it alleges that the summary plan description ("SPD") was inadequate in certain respects. Before me now are: (1) the Estate's motion for partial summary judgment on its claim for denial of benefits; (2) the Plan's motion for summary judgment on all claims; (3) the Plan's motion for a protective order to prevent discovery outside the administrative record; (4) the Plan's motion to strike a declaration; and (5) multiple motions to restrict the public's access to filings that reveal Gifford's medical information.

I. BACKGROUND

Gifford was a beneficiary of the Operating Engineers 139 Health Benefit Fund, which is a self-insured employee benefit plan established by the International Union of Operating Engineers Local 139 and its signatory employers to provide medical benefits to operating engineers and their dependents. The Plan is administered by a Board of Trustees. The Plan's SPD grants the Trustees discretion to interpret the Plan and determine eligibility for benefits. It provides:

> The Trustees or, where Trustee responsibility has been delegated to others, the other persons, will be the sole judges of the standard of proof required in any case and the application and interpretation of the Plan. Decisions of the Trustees or their delegates are final and binding. The Trustees or their delegates have broad discretion to determine eligibility for benefits and to interpret Plan language and their decisions will be accorded judicial deference in any subsequent action at a court or administrative proceeding.
>
> **Benefits under this Plan will be paid only when the Trustees decide, or persons delegated by the Trustees decide, in their discretion, that you or a beneficiary is entitled to benefits in accordance with the terms of the Plan.**

(ECF No. 33-1 at FUND000133 (emphasis in original).)

On July 4, 2021, Gifford was admitted to Froedtert South Hospital in Kenosha County, Wisconsin, where doctors determined that he was experiencing a stroke. After a

neurology consultation, doctors treated Gifford with a tissue plasminogen activator ("tPA" or "TPA"). Hospital records reflect that, "[s]hortly after receiving TPA, [Gifford's] weakness disappeared," and "[h]e was able to move his right upper and lower extremity just like prior to his symptoms." (ECF No. 33-2 at FUND000161.) Those records also reflect that Gifford's "symptoms resolved with TPA" (FUND000168) and that the tPA caused "complete resolution of symptoms" (FUND000180).

Because Gifford received the tPA, doctors required him to remain in the hospital under observation for 24 hours. On July 5, 2021, using the results of imaging performed as part of the treatment for the stroke, doctors diagnosed Gifford with a brain aneurysm. (FUND000167.) Specifically, using the results of a CT scan performed in the emergency department, doctors determined that Gifford had a "4x5mm anterior communicating artery aneurysm with prior evidence of bleeding." (FUND000180.) Hospital records describe the aneurysm as "incidental" and reflect that doctors thought that it would "need monitoring occasionally." (FUND000167) However, the doctors also referred Gifford to neurosurgery for a consultation that was scheduled for the next day. (*Id.*)

On July 6, 2021, Gifford consulted with Dr. Arvind Ahuja, a neurosurgeon who is not in the Plan's PPO network. After meeting with Gifford, Dr. Ahuja performed an angiogram that day to further evaluate the aneurysm. The angiogram revealed that the aneurysm was larger than previously believed and showed "evidence of prior bleeding." (FUND00172.) After Dr. Ahuja discussed his findings with Gifford, it was agreed that he would have brain surgery to "clip" the aneurysm. The surgery was scheduled for the next day. Dr. Ahuja performed the surgery on July 7, 2021. Medical records indicate that the clipping surgery "was apparently very challenging and complicated by bleeding issues."

(FUND000188.) Gifford did not regain consciousness after the surgery, and he died in the hospital on July 18, 2021.

Later, Dr. Ahuja's medical practice, Neurosurgery and Endovascular Associates, submitted a claim to the Plan for payment for the services provided to Gifford. The total amount billed was $189,208. (FUND000005.) The Plan denied the claim on the ground that Dr. Ahuja was an out-of-network provider and the services he rendered were not provided in the event of an emergency. The Plan's decision was based on the following Plan language:

> Out-of-Network
>
> The Plan maintains a broad network of providers who are part of the PPO network. **Out-of-network benefits are not covered under the Plan, subject to the following exceptions**:
>
> - In the event of an emergency, out-of-network treatment and services are covered. This also applies to emergency ambulance services
>
> . . . .
>
> Although the above listed services may be covered on an out-of-network basis, they are still subject to all other Plan limits and exclusions, including but not limited to deductibles, out-of-pocket maximums, Usual, Customary, and Reasonable limitations, and Medical Necessity.

(FUND000086.)

Following the denial, Suzanne Gifford, Mr. Gifford's widow, sent a letter to the Plan appealing the Fund's determination that Dr. Ahuja's treatment was not performed in the event of an emergency. (FUND000001.) In the appeal letter, Mrs. Gifford expressed her personal belief that the aneurysm required emergency brain surgery. She did not provide additional information about the surgery, such as medical records or a statement from Dr. Ahuja or another physician opining that the aneurysm required emergency surgery. Under

the Plan's appeal procedures, Mrs. Gifford had the right to provide such additional information. (FUND000122.)

After receiving Mrs. Gifford's appeal, the Plan contacted two outside medical review companies and asked them to review Mr. Gifford's medical records and determine if the surgery was due to an "emergency" and/or "medically necessary." The Plan provided these companies with the medical records that are in the district-court record at ECF No. 33-2. Dr. Luc Jasmin, a board-certified neurosurgeon working for Case Management Specialists, was one of the doctors to review these records. Dr. Jasmin's report, dated October 20, 2021, states that he reviewed "Hospital Documentation" from "Froedtert South" that was dated July 4, 2021 through July 19, 2021. (FUND000010.) The report states that the Plan had asked Dr. Jasmin to determine whether the surgical clipping of the aneurysm was considered medically necessary. Dr. Jasmin wrote that it was not. He explained that the aneurysm "was an incidental finding and could have been addressed in the following weeks on an outpatient basis." (FUND000011.) He also stated that there was "no indication that this aneurysm had bled or was about to rupture," and that "[n]o evidence was provided that there was an association between the unruptured aneurysm and the stroke." (*Id.*) Dr. Jasmin also opined that performing the aneurysm surgery so soon after Gifford's stroke likely exposed him to "a higher risk of complication than if it had been postponed to a later date." (*Id.*) Dr. Jasmin certified that his compensation was not determined by the outcome of his review. (FUND000012.)

The second outside neurosurgeon who reviewed the medical records was Dr. Paul Kaloostian of Medical Review Institute of America, LLC. His report states that it was based on "submitted clinical documentation." (FUND000007.) He states that the Plan had asked

him to determine whether a medical emergency required use of the hospital's staff neurosurgeon to treat the aneurysm, or whether there was time to contact an in-network neurosurgeon. (*Id.*) Dr. Kaloostian wrote that the medical records showed that a CT of the head performed as part of the treatment for the stroke revealed a "4mm anterior communicating artery (Acom) aneurysm non ruptured." (*Id.*) He then concluded:

> [T]here was no emergency and no stroke . . . noted for the date of service 07/07/21. The ACOMM aneurysm is small and completely incidental. The treating provider had time to contact the insurance regarding out of network services.

(*Id.*) Dr. Kaloostian also certified that his compensation did not depend on the outcome of his review. (FUND000008.)

The Plan's appeal committee met to consider Mrs. Gifford's appeal on October 26, 2021. Prior to the meeting, the committee members were provided with Mrs. Gifford's appeal letter, a summary of facts prepared by the Plan's administrator, and the opinions prepared by Drs. Kaloostian and Jasim. The committee denied the claim. The following entry was made in the minutes of the meeting:

> The Participant's wife appealed the denial of coverage for a surgery for a brain aneurysm in which the surgeon was not in Anthem's network. The Appellant believed the surgery was an emergency and should be covered. An independent medical review firm stated that the surgery was not an emergency. The reviewer stated that the aneurysm was small and completely incidental. Based on that response, the Fund Office requested an independent medical review of the medical necessity of the surgery. The reviewer stated that the surgery was not medically necessary. The aneurysm was an incidental finding and could have been addressed in the following weeks on an outpatient basis.
>
> ***Motion:* A motion was introduced, seconded, and unanimously carried to deny the appeal.**

(FUND000014.) The committee's decision was provided to the full Board of Trustees, which adopted the committee's decision at its November 11, 2021 board meeting. The

next day, the Plan sent a letter to Mrs. Gifford in which it explained its decision and provided her with copies of relevant documents, such as the reports from the medical reviewers and the minutes of the appeal committee's meeting.

In February 2022, the Estate of Michael Gifford, with Mrs. Gifford as special administrator, commenced the present action under ERISA. The Estate brings a claim to recover benefits under 29 U.S.C. § 1132(a)(1)(B) and a claim for appropriate equitable relief under 29 U.S.C. § 1132(a)(3). The latter claim alleges two defects with the Plan's SPD: (1) it does not adequately define emergency services, and (2) it does not provide a detailed description of the cost-sharing provisions applicable to out-of-network benefits. Because the Plan denied all coverage for out-of-network services, the claim based on the second defect would be relevant only if the Estate first established that the Plan should have paid the claim.

Before me now are several related motions. The first to be filed was the Plan's motion for a protective order, which it filed after the Estate served subpoenas on two of the Plan's trustees. In the motion, the Plan argues that, because the court must review the denial of benefits under the arbitrary-and-capricious standard, discovery outside the administrative record should not be permitted. After the Plan filed this motion, the Estate filed a motion for partial summary judgment seeking judgment in its favor on the claim for denial of benefits. In this motion, the Estate argues that, because the Plan did not provide certain medical records prepared by Dr. Ahuja to its outside medical reviewers, the Plan failed to perform a full and fair review of the claim. The Plan has filed its own motion for summary judgment. It contends that the arbitrary-and-capricious standard of review applies to the Estate's claim for denial of benefits and that the administrative record shows

that the Plan's decision was not arbitrary and capricious. In addition, the Plan argues that the Estate's claims for equitable relief under § 1132(a)(3) fail as a matter of law.

The parties have also filed several collateral motions relating to the above motions. First, the Plan has moved to strike a declaration from Dr. Ahuja that the Estate filed along with its reply brief in support of its motion for partial summary judgment. Second, both parties have filed multiple motions to restrict the public's access to parts of the record on the ground that they contain Mr. Gifford's medical records.

I consider these matters below.

II. DISCUSSION

I will first address the parties' motions for summary judgment. Because those motions implicate matters raised in the motion for a protective order, I will address that motion along with the motions for summary judgment. I will then turn to the collateral motion to strike and the motions to restrict access to certain parts of the record.

A. Motions for Summary Judgment

1. Summary Judgment Standard

Summary judgment is required where "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). When considering a motion for summary judgment, I view the evidence in the light most favorable to the non-moving party and must grant the motion if no reasonable juror could find for that party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 255 (1986).

2. Claim for Denial of Benefits

When an ERISA plan grants its administrator discretionary authority to interpret the plan and determine eligibility for benefits, the court must review the plan's decision

under the "arbitrary and capricious" standard. *Zall v. Standard Ins. Co.*, 58 F.4th 284, 291 (7th Cir. 2023). "Arbitrary-and-capricious review 'turns on whether the plan administrator communicated specific reasons for its determination to the claimant, whether the plan administrator afforded the claimant an opportunity for full and fair review, and whether there is an absence of reasoning to support the plan administrator's determination.'" *Id.* (quoting *Majeski v. Metropolitan Life Ins. Co.*, 590 F.3d 478, 484 (7th Cir. 2009).)[1]

In its briefs, the Estate does not dispute that the plan administrator communicated specific reasons for its determination to Mrs. Gifford or argue that the Plan's reasoning process was deficient. Instead, it contends that the Plan did not provide Mrs. Gifford with an opportunity for full and fair review.[2] This is so, the Estate argues, because the Plan did not provide its outside medical reviewers with certain parts of the medical record. Specifically, the Estate faults the Plan for not providing its reviewers with a document it describes as a "surgical note" authored by Dr. Ahuja. This document is in the district-court record at ECF No. 33-3 at GIFFORD000051–56. However, it is not part of the

[1] In its response to the Plan's motion for a protective order, the Estate disputes that the arbitrary-and-capricious standard applies. Its argument is that, because the Plan did not provide an opportunity for full and fair review, the court's review is *de novo*. (ECF No. 34 at 3.) However, as indicated in the text, whether the plan provided an opportunity for full and fair review is an aspect of arbitrary-and-capricious review. Thus, that is the standard I will apply. Still, this does not make a difference to the outcome here because the ultimate issue is whether the Plan provided an opportunity for full and fair review. If the Plan did not do so, then its decision cannot be upheld under any standard.

[2] The Estate also argues that the Plan did not follow plan language providing that, in the event of an appeal, "a new, full, and independent review of [the] claim will be made." (FUND000123.) Because the Estate does not argue that the plan language creates additional requirements beyond what is entailed in the requirement that the Plan provide an opportunity for full and fair review, I will not separately discuss the plan language.

administrative record that the Plan considered when denying the appeal. (*See* ECF Nos. 32-1 & 32-2 at FUND000001–239.)[3]

The document at issue appears to be two operative reports prepared by Dr. Ahuja after he completed the clipping surgery and an intraoperative angiogram. Each document contains a brief statement of Mr. Gifford's medical history during the days preceding the surgery, but these statements do not contain much information beyond noting that he was treated with tPA following stroke symptoms and was determined to have an aneurysm of the anterior communicating artery. The bulk of each document is devoted to describing the steps Dr. Ahuja took during the surgery and what he found while performing the surgery. Among other things, the surgical report states that Dr. Ahuja observed evidence that the aneurysm had ruptured and that he had observed a "spasm." (GIFFORD00005.)

Dr. Ahuja has submitted a declaration in which he describes where he obtained the surgical reports and what he believes they would mean to a reader with medical expertise.[4] (ECF No. 59.) He states that he authored the notes and then "entered [them] into Mr. Gifford's medical record." (*Id.* ¶ 7.) By "medical record," he means an electronic record maintained on the "Epic records system." (*Id.* ¶ 3.) This system "provides both the hospital and all treating physicians with seamless access to the patient's complete

[3] The administrative record—those documents actually considered by the Plan when deciding the claim—consists of the documents bates-labelled FUND000001–239. (Decl. of Rita Becker ¶ 3, ECF No. 44.)

[4] Dr. Ahuja has submitted two declarations. (ECF Nos. 47 & 59.) The first declaration, which was submitted along with the Estate's reply brief in support of its motion for partial summary judgment, is the subject of the Plan's motion to strike, and the Plan objects to the court's considering the second declaration on the ground that it was not part of the administrative record. The declarations contain substantially the same information, and I will describe the contents of the second declaration.

medical records." (*Id.* ¶ 15.) Dr. Ahuja was able to submit the surgical reports to the court by asking his staff to retrieve the reports from the Epic system. (*Id.* ¶ 4.) Dr. Ahuja claims that his surgical notes indicate that, after he performed imaging, but before surgery, he "identified Mr. Gifford's symptoms as stemming from vasospasm, following a small sentinel bleed from Mr. Gifford's aneurysm." (*Id.* ¶ 11.) He states that the "vasospasm diagnosis necessitated both the surgical procedure and its emergent timeframe." (*Id.* ¶ 12.) He opines that "a competent physician who reviewed the surgery note would have concluded that the presence of vasospasm meant that Mr. Gifford needed emergency surgery." (*Id.* ¶ 14.)

The Estate's position is that the Plan had an obligation to provide the surgical report to its outside medical reviewers when it asked them to determine whether the surgery was necessitated by an emergency. Again, however, the surgical report is not part of the administrative record. That is because the surgical report was not among the records that the Plan received from the hospital,[5] and because Mrs. Gifford did not provide it to the Plan as part of her appeal. Although Dr. Ahuja may have entered the report into the electronic record, there is no reason to think that the Plan had direct access to the Epic system. Indeed, that would be unlikely, since, as Dr. Ahuja explains, the system is designed for use by hospitals and treating physicians, not insurance companies and plan administrators. (ECF No. 59 ¶ 15.)

[5] All the medical records in the administrative record are accompanied by fax cover sheets indicating that they were sent by the hospital. *See* FUND000160–239. The latest fax was sent on July 19, 2021, at 10:12 a.m. *Id.* at FUND000195. The surgical reports were "last signed" by Dr. Ahuja on July 19, 2021, at 12:02 p.m., *see* GIFFORD000053 & 056, after the time of the last fax sent by the hospital.

Ultimately, then, the Estate's position is that the Plan, as part of its obligation to fully and fairly review the appeal, had a duty to realize that the surgical report was missing from the administrative record and to track it down. But the Estate cites no case or other authority holding that the obligation to provide an opportunity for full and fair review includes locating medical records that were not provided by the hospital where treatment was received. To the contrary, the Seventh Circuit has identified the "core requirements" of full and fair review without suggesting that the Plan is responsible for finding all relevant medical evidence. *Militello v. Cent. States, Se. & Sw. Areas Pension Fund*, 360 F.3d 681, 690 (7th Cir. 2004) (quoting *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 689 (7th Cir. 1992)). The court explained that the core requirements are: (1) knowing what evidence the decision-maker relied upon; (2) having an opportunity to address the accuracy and reliability of that evidence; and (3) having the decision-maker consider the evidence presented by both parties prior to reaching and rendering the decision. *Id*. The Estate does not contend that these core requirements were absent from Mrs. Gifford's appeal.

Moreover, as the third core requirement of full and fair review implies, the burden to locate and provide additional records that support the appeal is on the plan participant. If Mrs. Gifford believed that the surgical report was an important record that the Plan needed to consider before deciding her appeal, she could have submitted it, and it would now be part of the administrative record.[6] Even better, Mrs. Gifford could have asked Dr. Ahuja to include the information that he now includes in his declaration in a written

[6] I recognize that Mrs. Gifford was not represented by counsel during the administrative appeal. However, the Estate has not argued that her unrepresented status excused her from submitting evidence that the Estate now deems important to its claim.

statement to the Plan. Had Mrs. Gifford provided such evidence and the Plan ignored it, the Estate would have a strong argument that the Plan violated its obligation to provide an opportunity for full and fair review. *See Majeski v. Metropolitan Life Ins. Co.*, 590 F.3d 478, 484 (7th Cir. 2009) ("[b]y ignoring Majeski's key medical evidence, MetLife can hardly be said to have afforded her an opportunity for full and fair review"). But the Plan was not obligated to realize on its own that the surgical report was missing and important.

To support its claim that the Plan was obligated to find the surgical report and provide it to its medical reviewers, the Estate relies heavily on *Garner v. Central States, Southeast & Southwest Areas Health & Welfare Fund Active Plan*, 31 F.4th 854 (4th Cir. 2022). In that case, the plan asked an outside medical reviewer to determine whether the claimant's spinal surgery was medically necessary. The reviewer determined that it was not. In his report, the reviewer specifically noted the absence of an official MRI report and documentation concerning the severity of the symptoms and whether they impacted the patient's daily activities. The plan possessed the official MRI report and office notes from the patient's doctor that explained his reasons for recommending the surgery, but it did not provide them to the reviewer even after the reviewer noted that documents of this sort were absent from the medical record. *Id.* at 858. The Fourth Circuit held that the plan's relying on the reviewer's opinion to deem the surgery medically unnecessary while having reason to know that it had not provided him with relevant medical records was arbitrary and capricious. *Id.*

The present case is distinguishable from *Garner* because, here, the Plan did not fail to provide its medical reviewers with records that it had reason to know were missing and relevant to the reviewers' opinions. As explained above, the surgical report was not

part of the set of medical records provided to the Plan by the hospital. Moreover, the Plan's medical reviewers did not specifically note the lack of a particular record, like the reviewer in *Garner* did with the respect to the MRI report. And Mrs. Gifford did not rely on this record, or note its absence, during her administrative appeal. The first time anyone suggested that this record was missing and important was during the prosecution of the present lawsuit. Accordingly, *Garner* does not suggest that the Plan failed to provide Mrs. Gifford with an opportunity for full and fair review or otherwise support the Estate's claim that the Plan's decision was arbitrary and capricious.

Because the Plan's failure to discover the surgical report on its own did not amount to a denial of an opportunity for full and fair review, I return to the administrative record and ask whether, in light of that record, the Plan's decision was arbitrary and capricious. The Estate does not argue that it was. And for good reason. The only medical opinions in the administrative record were those of the Plan's outside reviewers, who concluded that the surgery was not medically necessary or a response to an emergency. Based on such a record, the only rational conclusion was to deny the claim.

In its response to the Plan's motion for a protective order, the Estate contends that I must factor the Plan's potential conflict of interest into my review of the decision to deny benefits. The Estate also contends that it is entitled to discovery to determine the extent or severity of the conflict. The Estate's position is based on *Metropolitan Life Insurance Co. v. Glenn*, 554 U.S. 105 (2008). There, the Court held that a structural conflict of interest exists when "the entity that administers the plan, such as an employer or an insurance company, both determines whether an employee is eligible for benefits and pays benefits out of its own pocket." *Id.* at 108. Prior to *Glenn*, the Seventh Circuit took

the position that, when the plan's determination is reviewed under the arbitrary-and-capricious standard, discovery about a potential conflict of interest is precluded unless the claimant identifies a specific conflict and makes a prima facie showing that limited discovery would be relevant to determining the extent of the conflict. *Semien v. Life Ins. Co. of N. Am.*, 436 F.3d 805, 815 (7th Cir. 2006). After the Supreme Court decided *Glenn*, the Seventh Circuit recognized that there may have been a "softening, but not a rejection, of the standard announced in *Semien*." *Dennison v. MONY Life Retirement Income Sec. Plan for Employees*, 710 F.3d 741, 747 (7th Cir. 2013). However, the Seventh Circuit has not identified the precise circumstances under which a court should permit discovery into a structural conflict of interest.

Initially, I note that there is reason to doubt that this case presents a structural conflict of interest of the type identified in *Glenn*. That type of conflict occurs in a single-employer plan where the employer (or its insurer) both has discretion to determine eligibility for benefits and pays benefits when due. *See Glenn*, 554 U.S. at 108. In the present case, the Plan is a multi-employer plan administered by a Board of Trustees composed of an equal number of union and management representatives who voted unanimously to deny Mrs. Gifford's appeal. (FUND000017; *see also* FUND000014 (appeals committee composed of equal number of labor and management representatives voted unanimously to deny appeal).) The Seventh Circuit has recognized that a structural conflict is not present in such multiemployer plans. *Rabinak v. United B'hood of Carpenters Pension Fund*, 832 F.3d 750, 755 (7th Cir. 2016); *see also Manny v. Cent. States, Se. and Sw. Areas Pension & Health & Welfare Funds*, 388 F.3d 241, 243 (7th Cir. 2004).

In any event, even when *Glenn* applies, the conflict of interest acts only as "tiebreaker" when the administrator denies a "borderline" claim. *Rabinak*, 832 F.3d at 755; *see also Dragus v. Reliance Standard Life Ins. Co.*, 882 F.3d 667, 673 (7th Cir. 2018). Here, the administrative record shows that the Plan was not confronted with a borderline claim. The Plan sought medical opinions from two medical review services, and the neurosurgeons who reviewed the medical records certified that their compensation was not affected by the outcome of their review. (FUND000008 & 12.) One reviewer determined that the aneurysm did not require emergency surgery, and the other determined that the surgery was not medically necessary at all. Mrs. Gifford did not submit contrary medical evidence in support her claim that the surgery was a medically necessary response to an emergency. Based on the administrative record, the only rational conclusion that the Plan could have reached was that the surgery was not covered. Thus, even if a conflict of interest existed, it would not have affected the outcome of the appeal.

Because any conflict of interest would have been inconsequential, discovery on the extent of that conflict is unwarranted. I will therefore exercise my discretion under Federal Rule of Civil Procedure 26(c) and grant the Plan's motion for a protective order relating to the Estate's claim for the denial of benefits.[7] Further, because the denial of

[7] In its response to the motion for a protective order, the Estate also argued that discovery was warranted on the question of whether the administrative record is actually complete. (ECF No. 34 at 8.) The Estate's claim that the record might be incomplete was based on the possibility that the Plan had failed to "review the full medical records" before denying the appeal. (*Id.*) However, proceedings on the motion for summary judgment have made clear that the records at issue—Dr. Ahuja's surgical reports—were not part of the administrative record and were not reviewed by the Plan. Thus, there is no need for discovery to confirm these facts.

benefits was not arbitrary and capricious, I will grant the Plan's motion for summary judgment on this claim and deny the Estate's motion for partial summary judgment.

3. Claims for Other Appropriate Equitable Relief

The Estate's remaining claims are for other appropriate equitable relief under 29 U.S.C. § 1132(a)(3). These claims allege that the Plan SPD is deficient because (1) it does not adequately define emergency services, and (2) it does not provide a detailed description of the cost-sharing provisions applicable to out-of-network benefits. Because I have determined that the Plan properly denied the Estate's claim for out-of-network benefits in its entirety, the Estate's claim regarding the amount that the Plan should have paid if it determined that the Estate was entitled to benefits is moot. Thus, I will discuss only the Estate's claim regarding the definition of an emergency.

Here, the Estate's legal theory is difficult to discern. The Estate contends that the term "emergency," as it appears in the SPD, has a plain meaning that the Plan failed to apply when it denied the claim for benefits. (ECF No. 58 at 22 of 29.) But this theory does not allege a deficiency in the SPD; it alleges a deficiency in the Plan's *interpretation* of the SPD. Therefore, the argument is really an alternative claim under § 1132(a)(1)(B) that the Plan improperly denied benefits. However, the Plan grants the Trustees discretion to interpret Plan terms (FUND000133), and therefore I must defer to their interpretation so long as it "falls within the range of reasonable interpretations." *Bator v. Dist. Council 4*, 972 F.3d 924, 929 (7th Cir. 2020).

The Estate's argument is that a surgery is performed in the event of an emergency if the surgeon who performs the surgery decides that the patient requires emergency surgery. (ECF No. 58 at 22 of 29 & n.10.) The Estate cites no authority in support of this

interpretation. Further, to the extent that it is a reasonable interpretation of the SPD, it is not the only reasonable interpretation. The Estate's interpretation does not turn on the meaning of the word "emergency" at all. Instead, it focuses on *who decides* whether an emergency—a need for immediate treatment—is present. The Estate contends that the treating provider's opinion is dispositive: if the provider tells the patient that an emergency is present, then the Plan must agree. But the Plan could reasonably construe the SPD to mean that the Trustees may review the medical records, obtain opinions from outside reviewers, and make an independent determination of whether immediate treatment was required. Therefore, the Plan's interpretation was not arbitrary and capricious.

The Estate also contends that the Plan has taken the position that "there could never be another emergency after Mr. Gifford's stroke." (ECF No. 58 at 23 of 29.) This is incorrect. The Plan has not claimed that if a second emergency was discovered during treatment for the stroke, treatment for the second emergency would not be covered. Instead, it determined that Mr. Gifford's aneurysm was not a second emergency. As one of the Plan's reviewers opined, the aneurysm "could have been addressed in the following weeks on an outpatient basis." (FUND000011.) A condition that may be addressed weeks later is not, under any reasonable understanding of the term, a medical emergency.

Accordingly, the Plan is entitled to summary judgment on the Estate's claims under § 1132(a)(3). Because those claims turn on an interpretation of the SPD, rather than on facts that might require further discovery, I will grant the Plan's motion for a protective order to preclude discovery in connection with such claims.

B. The Plan's Motion to Strike

The Plan has moved to strike the declaration (ECF No. 47) that Dr. Ahuja submitted in support of the Estate's reply brief in support of its own motion for partial summary judgment. The Plan argues that striking the declaration is appropriate for several reasons, including that it was submitted in support of a reply brief, when it was too late for the Plan to submit a response. I will strike the declaration for this reason. The Estate raised the issue of the Plan's failure to consider the surgery report in its opening brief, and it should have submitted Dr. Ahuja's declaration, which authenticates and explains the report, along with that brief. *See Black v. TIC Inv. Corp.*, 900 F.2d 112, 116 (7th Cir. 1990). However, because Dr. Ahuja submitted a second declaration in connection with the Estate's response to the Plan's motion for summary judgment that contains substantially the same information, granting the motion to strike has had no effect on the outcome of the motions for summary judgment.

C. Motions to Restrict Access to the Record

The parties have filed motions to restrict public access to much of the record on the ground that it contains Mr. Gifford's medical information. But any documents that "influence or underpin the judicial decision are open to public inspection unless" the documents include "trade secrets," "information covered by a recognized privilege," or "information required by statute to be maintained in confidence." *Baxter Int'l, Inc. v. Abbott Labs.*, 297 F.3d 544, 545–46 (7th Cir. 2002). This entire case is about Mr. Gifford's medical records, and his records influenced or underpinned my decisions on the motions for summary judgment. Although various statutes regulate the privacy of medical records, none applies to records relating to matters that the patient placed at issue by filing a

lawsuit. Rather, courts have generally found that such records should be open to public inspection when they relate to matters decided by the court. *See Mitze v. Saul*, 968 F.3d 689, 692–93 (7th Cir. 2020); *Bradley v. Van Norman*, No. 20-cv-49-jdp, 2022 WL 594542, at *2 (W.D. Wis. Feb. 28, 2022). Accordingly, I will deny the parties' motions to restrict access to the medical records.

III. CONCLUSION

For the reasons stated, **IT IS ORDERED** that the Plan's motion for summary judgment (ECF No. 53) is **GRANTED**.

IT IS FURTHER ORDERED that the Estate's motion for partial summary judgment (ECF No. 35) is **DENIED**.

IT IS FURTHER ORDERED that the Plan's motion for a protective order (ECF No. 26) is **GRANTED**.

IT IS FURTHER ORDERED that the Plan's motion to strike (ECF No. 50) is **GRANTED**.

IT IS FURTHER ORDERED that the parties' motions to restrict access (ECF Nos. 32, 40, 45, 49, 52, 61 & 63) are **DENIED**. The Clerk of Court shall ensure that all documents in the record are available for public viewing.

FINALLY, IT IS ORDERED that the Clerk of Court enter final judgment.

Dated at Milwaukee, Wisconsin, this 23rd day of June, 2023.

/s/Lynn Adelman
LYNN ADELMAN
United States District Judge