No. 12-729

In The Supreme Court of the United States

JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO. AND WAL-MART STORES, INC.

Respondents.

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

BRIEF OF AMICI CURIAE AARP AND NATIONAL EMPLOYMENT LAWYERS ASSOCIATION IN SUPPORT OF PETITIONER

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INTERESTS OF AMICI CURIAE[1]

AARP is a nonprofit, nonpartisan organization, with a membership that helps people turn their goals and dreams into real possibilities, seeks to strengthen communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse. In its efforts to foster the economic security of individuals as they age, AARP seeks to increase the availability, security, equity, and adequacy of public and private pension, health, disability and other employee benefits which countless members and older individuals receive or may be eligible to receive.[2]

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[1] In compliance with Rule 37 of this Court, counsel for amici state that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amici, its members, or its counsel made a monetary contribution to the preparation or submission of this brief. Counsel of record for all parties received notice at least 10 days prior to the due date of the intention to file this brief. The parties have consented to the filing of this brief.

[2] AARP and the National Employment Lawyers Association have, jointly and singly, participated as amicus curiae in this Court to protect the rights of workers and their beneficiaries under ERISA. *See*, *e.g.*, *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013); *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011); *Metro. Life Ins. Co. v. Glenn,* 554 U.S. 105 (2008); *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

The National Employment Lawyers Association (NELA) is the largest professional membership organization in the country comprised of lawyers who represent workers in labor, employment and civil rights disputes. Founded in 1985, NELA advances employee rights and serves lawyers who advocate for equality and justice in the American workplace. NELA and its 68 circuit, state, and local Affiliates have a membership of over 3,000 attorneys who are committed to working on behalf of those who have been illegally treated in the workplace. NELA's members litigate daily in every circuit, affording NELA a unique perspective on how the principles announced by the courts in employment and benefit cases actually play out on the ground. NELA strives to protect the rights of its members' clients, and regularly supports precedent-setting litigation affecting the rights of individuals in the workplace, including through cases to protect employee benefits.

Participants in private, employer-sponsored employee benefit plans rely on ERISA to protect their rights under those plans. See Title I – Protection of Employee Benefit Rights, 29 U.S.C. §§ 1001-1191(c). In particular, ERISA's protections, and plan participants' opportunities to enforce the statute's protections, are of vital concern to workers of all ages and to retirees, since the quality of their lives depends heavily on their eligibility for and the amount of their retirement and welfare benefits.

In order to ensure that they are receiving the benefits to which they are entitled, participants must be able to successfully access and resolve benefits

disputes through ERISA's claims procedures. In particular, participants must know the deadline to file a lawsuit if they have been unable to successfully resolve a dispute with their plan over the eligibility for and amount of benefits. If claimants miss the deadline for filing suit because there is no bright line for determining that deadline, they cannot adequately protect their claims to benefits. This may spell the difference between filing for bankruptcy or not. For example, with $768 as the median weekly earning of a fulltime worker, *see* U. S. Dep't of Labor, *Labor Force Statistics from the Current Population Survey: Table 37*, Bureau of Labor Statistics (last modified Feb. 5, 2013), http://www.bls.gov/cps/cpsaat37.htm), and a replacement percentage of sixty percent, see America's Health Ins. Plans (AHIP), *Disability Insurance: A Missing Piece in the Financial Security Puzzle*, 27 (Oct. 2004), http://www.ahipresearch.org/PDFs/27_AHIPDIChartBook.pdf, a disability claimant would receive the modest amount of approximately $460 per week.[3]

The Court's ruling in this case will apply to ERISA benefit claims of all kinds – pension and retirement benefits, health, life insurance, and other welfare benefits in addition to disability benefits –

[3] For participants at retirement age, even a modest increase in benefit amounts may spell the difference between independence and impoverishment in old age. U.S. Dep't of Commerce, *Preliminary Estimate of Weighted Average Poverty Thresholds for 2012,* U.S. Census Bureau (Jan. 18, 2013), http://www.census.gov/hhes/www/poverty/data/threshld/index.html (2012 poverty threshold for a single person age 65 or older is about $11,000).

and thus resolution of the issues in this case will have a direct and vital bearing on plan participants' ability to protect their claims concerning their benefits. In light of the significance of the issues presented by this case, AARP and NELA respectfully submit this brief, as amici curiae, to facilitate a full consideration by the Court on the issue of the accrual of a benefit claim prior to the completion of the judicially created mandatory requirement of the exhaustion of the plan's internal claims procedure.

SUMMARY OF ARGUMENT

In *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1546-49 (2013), this Court reaffirmed that clear plan terms are enforceable. However, this rule is of no help in this case because the plan term at issue does not address the question certified by the court. Thus, an implied term is necessary to make the plan term surrounding the limitations period workable. So, this case presents this Court with the question of which implied term to read into Respondent's long-term disability ERISA plan.[4] Respondent urges the

[4] Although amici acknowledge that this case has been presented to the Court as one arising under a contract, *see Mertens v. Hewitt Assocs.*, 508 U.S. 248, 253-55 (1993) ("we decide this case on the narrow battlefield the parties have chosen"), we question whether this is appropriate given that ERISA actions for benefits are equitable in nature and are subject to the rules that govern equity courts, which generally will not apply a limitations period to a beneficiary's action to enforce the terms of an express trust absent a showing of prejudice to defendant. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989); *Adams v. Cyprus Amax Minerals Co.*, 149 F.3d 1156, 1160-61 (10th Cir. 1998) (§ 502(a)(1)(B) "claims are

Court to adopt a term requiring that the time from cause of action accrual to the expiration of the contractual limitations must be "reasonable" under all the facts and circumstances of a particular case. As a secondary argument, Petitioner urges the Court to adopt a term tolling of the contractual limitations period during the time a claimant is unable to bring suit because of mandatory claims exhaustion.

Amici agrees with Petitioner's alternative argument. A tolling provision is the far better implied term because it provides a bright line test, is fair to all parties, and facilitates ERISA's goal of providing a thoughtful, full, fair and frank exchange of information and a complete dialogue between them. *See Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005).

Reading a "reasonableness" term into the contract, on the other hand, requires trial courts to determine the contours of a new road and the standards to apply to this reasonableness. Most often, reasonableness will depend on a thorough (and largely pointless) examination of the facts of each case, including which party was responsible for the delay, whether there was good faith, bad faith or, more likely, inappropriate manipulation of the system. Amici suggest that with the continuing reduction of already limited judicial resources, such examinations are not time well spent as it serves no

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fundamentally equitable in nature," and "analogous to a trust action."); *Wardle v. Cent. States Pension Fund*, 627 F.2d 820, 829 (7th Cir. 1980) ("suits for pension benefits by disappointed applicants are equitable" in character).

worthwhile public policy. *See, e.g.*, Admin. Office of the U.S. Cts., *Federal Judiciary Braces for Broad Impact of Budget Sequestration*, The Third Branch News (March 12, 2013), http://news.uscourts.gov/federal-judiciary-braces-broad-impact-budget-sequestration; Admin. Office of the U.S. Cts., *Survey Shows Impact of Reduced Resources*, The Third Branch News (June 04, 2012), http://news.uscourts.gov/survey-shows-impact-reduced-resources; *see also* Amy Covert & Aaron Feuer, *View From Proskauer: The Supreme Court to Opine on Use of Contractual Limitation Periods in ERISA Plans*, Bloomberg Law (2013), http://about. bloomberglaw.com/practitioner-contributions/the-supreme-court-to-opine-on-use-of-contractual-limitation-periods-in-erisa-plans/ ("The Fourth Circuit refused to adopt a case-by-case, fact-intensive assessment of the reasonableness of the accrual provision.").

ARGUMENT

Amici contend that the Court will have to choose to rewrite the plan by adding an implied term to the plan – choosing either a "reasonableness" provision or a "bright line" provision. Between the two provisions at issue, the narrower alternative and the one far more consistent with other ERISA specifications, *see, e.g.*, *infra* at 21-23, is the bright line rule which tolls the statute of limitations so that the mandatory exhaustion of the internal claims procedure may be completed. *See generally Reiter v. Cooper*, 507 U.S. 258, 267 (1993) ("While it is theoretically possible for a statute to create a cause of action that accrues at one time for the purpose of

calculating when the statute of limitations begins to run, but at another time for the purpose of bringing suit, we will not infer such an odd result in the absence of any such indication in the statute"). Here, by only applying the plan language, the Second Circuit's supports "an odd result." *See id.; cf. U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1548 (2013) (if a plan wants to "depart from the well-established common-fund rule, it had to draft its contract to say so"). Instead, the bright line rule informs all parties of the exact deadline for the filing of a lawsuit, while the reasonableness rule does not. ERISA demands such exactitude to fulfill its primary policies. *See* Section 2(b), 29 U.S.C. § 1001(b) (participants must have "ready access to the Federal courts" to remedy a denial of a benefit claim in accordance with Congress' policy as set forth in ERISA).

I. A CAUSE OF ACTION ACCRUING BEFORE THE COMPLETION OF THE MANDATORY INTERNAL CLAIMS REVIEW PROCESS IS AT ODDS WITH THE JUDICIALLY CREATED EXHAUSTION REQUIREMENT.

A. Courts Have Characterized The Exhaustion Requirement As A "Win-Win" For Both Participants And Plans.

ERISA requires that all employee benefit plans must include a claims and appeals procedure which provides adequate notice in writing to any

participant of a denied benefit claim, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and affording a participant with "a reasonable opportunity" "for a full and fair review" of that denied claim. Section 503, 29 U.S.C. § 1133. However, the statute itself does not mandate that participants must exhaust internal claims procedures before proceeding to court. Instead, the mandatory exhaustion requirement was judicially created. *See Amato v. Bernard*, 618 F.2d 559, 566-67 (9th Cir. 1980); *Whitehead v. Okla. Gas & Elec. Co.*, 187 F.3d 1184, 1190 (10th Cir. 1999) (ERISA exhaustion is a judicial, not contractual, doctrine). "Virtually all of the federal circuits have recognized the exhaustion requirement." *Fallick v. Nationwide Mut. Ins. Co.*, 162 F.3d 410, 418, n.4 (6th Cir. 1998) (listing cases).

Courts have explained the many purposes of exhausting internal remedies. A review of the legislative history indicates that the main reason was to provide participants with a simple, low cost, efficient, fair method to protect their benefit rights. *See Richardson v. Cent. States, Se. & Sw. Areas Pension Fund*, 645 F.2d 660, 665 (8th Cir. 1981) ("The statute and the regulations were intended to help claimants process their claims efficiently and fairly; they were not intended to be used by the Fund as a smoke screen to shield itself from legitimate claims"); *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 693 (7th Cir. 1992) (exhaustion of internal process "enables the claimant to prepare adequately for appeal to the federal courts"); *Taylor v. Bakery & Confectionary Union & Indus. Int'l Welfare Fund*,

455 F. Supp. 816, 820 (E.D.N.C. 1978) (employees would incur costs "because, rather than utilize a simple procedure which allows them to deal directly with their employer, they would have to employ an attorney and bear the costs of adversary"); *see generally* Jay Conison, *Suits For Benefits Under ERISA*, 54 U. Pitt. L. Rev. 1, 21-25 (1992) (reviewing ERISA's legislative history of §§ 502 and 503).

Courts have also focused on the benefits that a mandatory exhaustion requirement provides the plan. The benefits to the plan range from enhancing the ability of plan fiduciaries to expertly and efficiently manage their funds by preventing premature judicial intervention in their decision-making processes and permitting the internal plan procedures to work, *Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir. 1980); providing trustees with the time to interpret plan provisions and correct their errors, *Costantino v. TRW, Inc.*, 13 F.3d 969, 975 (6th Cir. 1994); promoting uniform processing and consistent treatment of benefit claims, *id.*; reducing litigation costs, *Amato* 618 F.2d at 567; *Grossmuller v. UAW*, 715 F.2d 853, 857 (3d Cir. 1983); and reducing frivolous lawsuits; *Amato*, 618 F.2d at 567. Of particular importance to the courts is that exhaustion of the internal claims procedure helps to assemble a record of the fully considered actions by fiduciaries interpreting their plans and further refines the issues, thus assisting courts when they are called upon to resolve disputed claims. *Amato*, 618 F.2d at 568.

"[T]he end product of a claims review process wherein § 1133 and its regulations have been followed faithfully is a benefits decision that is thoroughly informed by the relevant facts and the terms of the plan and, if benefits are denied, includes an explanation of the denial that is adequate to insure meaningful review of that denial." *Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388 (5th Cir. 1998). It is only after participants have exhausted plans' internal appeals procedure that they can file suit,[5] if they so desire.

B. The Mandatory Exhaustion Requirement Has Been Successful In Reducing The Number Of Lawsuits Filed To Recover Benefits.

There are millions of claims filed with plans every year, with most of them paid and not disputed. *Cf.* U.S. Dep't of Labor, *Private Pension Plan Bulletin Abstract of 2010 Form 5500 Annual Reports*, Emp. Benefits Sec. Admin., 1-3 (Nov. 2012), http://www.dol.gov/ebsa/PDF/2010pensionplanbulletin.pdf (701,000 pension plans with 1.29 billion participants); U.S. Dep't of Labor, *Group Health Plans Report Abstract of 2010 Form 5500 Annual Reports*, Emp. Benefits Sec. Admin., 1-3 (Dec. 2012), http://www.dol.gov/ebsa/pdf/ACA-ARC2013.pdf (48,544 group health plans with 68 million participants). It can be deduced that each year, millions of claims are also appealed under plans'

[5] In extremely limited circumstances, courts have recognized exceptions to the exhaustion requirement. *See generally* Jeffrey Lewis et al., *Employee Benefits Law* 13-39-41 (3d ed. 2012).

internal claims process. *E.g.*, *Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2350 (2008) (noting that approximately "1.9 million beneficiaries of ERISA plans have health care claims denied each year") (citing Gresenz, C., et al., *A Flood of Litigation? Predicting the Consequences of Changing Legal Remedies Available to ERISA Beneficiaries,* Health Rand Law, 8 (1999), http://www.rand.org/pubs/issue_papers/2006/IP184.pdf (all Internet materials as visited June 9, 2008, and available in Clerk of Court's case file).[6] Yet for all of the claims filed, appealed, and decided under the internal claims procedure of plans, there is only a miniscule fraction of benefit denials funneled into actual litigation in any court. *See, e.g.*, Susan M. Mangiero, *ERISA Fiduciaries Beware: Risk Is More Than a Four-Letter Word*, 19 Prob. & Prop. 65, 65 (2005) ("According to the Admin. Office of the U.S. Cts., new [ERISA] cases [numbered] 9,167 ... in 2000 [and] 11,499 ... in 2004."). Clearly, the judicially created exhaustion requirement has effectively worked to reduce the number of cases that are filed under section 502(a)(1)(B). *See Commc'n Workers of Am. v. AT&T*, 40 F.3d 426, 432 (D.C. Cir. 1994) ("the exhaustion requirement may render subsequent judicial review unnecessary in many ERISA cases because a plan's own remedial procedures will resolve many claims").

[6] This statistic does not include denials of claims for retirement, disability, life insurance, and other employer sponsored benefits.

II. A BRIGHT LINE IMPLIED CONTRACT TERM COMMENCING ON THE DATE OF A FINAL BENEFIT DENIAL IS THE ONLY IMPLIED TERM CONSISTENT WITH A MEANINGFUL CLAIMS PROCEDURE AND MANDATORY EXHAUSTION.

Because the exhaustion requirement has worked so well, it makes no sense to permit plans to adopt accrual rules which are so at odds with the purposes for requiring mandatory exhaustion.

First, under the plain language of Section 502(a)(1)(B), there can be no civil action until there is reason to recover benefits due under the plan, *i.e.* a denial of a claim. Thus, Section 502(a)(1)(B) should be read as starting the accrual period when the claimant receives notification that the claim is finally denied because there is no injury relating to a benefit denial until the mandated claims procedure is concluded.[7] This reading is the result of the judicially imposed requirement that a plan's internal claims procedure must be exhausted before the cause of action accrues.

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[7] This would be consistent with those circuit courts that have permitted the accrual of a benefit denial to commence when the participant has received a clear and final repudiation of the claim. *See Miller v. Fortis Benefits Ins. Co.*, 475 F.3d 516, 521 (3d Cir. 2007) (citing cases) ("clear repudiation" means a fiduciary repudiates a claim for benefits and that repudiation is clear and made known to the participant).

Second, a bright line term – the cause of action accrues begins after the internal claims process is complete – provides the participant with notice that the time has started to run for the filing of his or her lawsuit. The participant will know when the limitations period expires because it has a fixed beginning date – the date there is a "clear and continuing repudiation" of the claim, which also happens to be the time a claimant is first allowed to bring suit.

Third, a bright line term also avoids potential misuse by plans which may adopt buried pre-exhaustion accrual date periods. We know from past experience that plans will add these provisions to the plan along with short limitations periods, thereby reducing the time for claimants to file a lawsuit to protect their benefits to incredibly short periods. Adding plan provisions in response to Supreme Court decisions has occurred before, *see* Brendan Maher, *Creating A Paternalistic Market For Legal Rules Affecting The Benefit Promise*, 2009 Wis. L. Rev. 657, n.76 (2009) (detailing the rush of plans to incorporate discretionary clauses into their plans after *Firestone*), with well-known misuse by certain plans and providers. *See* John Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA*, 101 Nw. U. L. Rev. 1315 (2007). Indeed, the misuse of the discretionary clause approved by this Court in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), was so open and notorious that not only did courts comment on it, *e.g.*, *Radford Trust v. First Unum Life Ins. Co.*, 321 F. Supp. 2d 226, 247 (D.

Mass. 2004), *rev'd in part, appeal dismissed in part*, 491 F.3d 21 (1st Cir. 2007) (Unum's claim processing was a "pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics."), but the National Association of Insurance Commissioners enacted a Model Act to ban such clauses, Henry Quillen, *J. Pension Planning & Compliance*, Summer 2006, at 67, which now has been adopted in some form by almost half of the states, ironically making state laws more protective of participants than ERISA on this issue. *See* NBC 10, *I-Team: New law bans discretionary clauses* (Jun 25, 2013), http://www.turnto10.com/story/22685544/i-team. It is not an overstatement to say that plan counsel are lying in wait for the decision in this case. See Amy Covert & Aaron Feuer, *View From Proskauer: The Supreme Court to Opine on Use of Contractual Limitation Periods in ERISA Plans,* Bloomberg Law (2013), http://about.bloomberglaw.com/practitioner-contributions/the-supreme-court-to-opine-on-use-of-contractual-limitation-periods-in-erisa-plans/ ("Pension plans could include provisions requiring that a challenge to benefit calculations must be filed within a reasonable period after a participant receives an annual statement of his or her accrued benefit, or when the participant terminates employment, rather than at the point of retirement"); Patrick Begos, *Statute of Limitations Can Start Running Before Claim Accrues,* ERISA Claim Defense Blog (Sept. 24, 2012), http://www.erisaclaimdefense.com/statute-of-limitations-can-start-run ning-before-claim-accrues/; Aaron A. Reuter, *Limiting ERISA's Limitations Period through the Use of Contractual Accrual Dates*, ERISA

Litigation Newsletter, 6 (April 2012), http://www.proskauer.com/files/News/a985a557-a73c-4770-bf45-87058e7fda8b/Presentation/NewsAttachment/661ecf5a-cc57-47e4-9baf-9d3b82b28d12/erisa-litigation-newsletter-apr il-2012.pdf; Myron D. Rumeld, Russell L. Hirschhorn & Brian Neulander, *ERISA's Statute of Limitations for Benefit Claims: Where To Begin?*, ERISA Litigation Newsletter, 4 (July 2010), http://www.proskauer.com/publications/newsletters/erisa-litiga tion-newsletter-july-2010/; Jennifer Saba & Russell Greenblatt, *The Potential Advantage of Incorporating a Contractual Limitations Period into Welfare Benefit Plans*, 21 Benefits L. J. 59 (2008).

Thus, it is not a farfetched conclusion that there will be substantial incentives for some plans and providers to delay resolution of benefit claims so that participants will not have the ability to file suit. This could happen in two ways. The decision on the claim could be so delayed that the claimant does not realistically have time to review the claim, obtain a lawyer and file suit. Even worse, the claim could be decided after the accrual period has run, totally depriving claimants of their right to file suit to protect their benefit claims. Alternatively, lawsuits may be filed prematurely because counsel does not have sufficient time to scrutinize the claim and explain the case to the claimant before the statute of limitations has run.

Even if a plan does not intentionally delay benefit claims decisions, the internal review process can take much longer than the potential accrual time frames and even the time frames in the interpretive

regulations. For example, in reviewing disability claims, medical records must be obtained, independent medical examinations may be sought for various assessments and outside evaluators may be used, adding substantial time to the process. *E.g.*, *McCauley v. First Unum Life Ins. Co.*, 551 F.3d 126 (2d Cir. 2008) (awarding the claimant disability benefits thirteen years after his first application).

Claims for disability pensions raise similar issues to long-term disability claims, plus many retirement plans first require a participant to obtain a Social Security disability determination in order to meet the plan's eligibility requirements. Applying for Social Security retirement and going through the Social Security appeals process, if necessary, can take close to three years. Soc. Sec. Admin., *Waiting Period for Social Security Disability* (Feb. 20, 2013), http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/151/related/1/session/L2F2LzEvdGltZS8xMzcxNzMxODM0L3NpZC80R0N2VWN0bA%3D%3D ("The five month waiting period ensures that during the early months of disability, we do not pay benefits to persons who do not have long-term disabilities."); Soc. Sec. Admin., *Length of time to receive approval or denial decision on disability claim* (June 15, 2013), http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/159/~/length-of-time-to-receive-approval-or-denial-decision-on-disability-claim ("The length of time it takes to receive a decision on your disability claim is from three to five months."); Soc. Sec. Admin., *Time frames during the hearing process* (Dec. 4, 2012), http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/1160/kw/how%20long%20does%20it%20take%20alj%20to%20dec

ide%20my%20case ("The average amount of time needed to process a hearing request during fiscal year 2010 was 426 days."); Soc. Sec. Admin., *Length of time it takes the Appeals Council to decide my case* (Mar. 31, 2013), http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/1167/kw/how%20long%20does%20it%20take%20to%20appeal%20a%20disability%20denial ("The Appeals Council take about a year to give proper consideration to each case to ensure the agency's final action is correct.").

Even an apparently generic pension claim can result in a prolonged deliberation if there are questions over a participant's work history and crediting of service. Myron D. Rumeld, Russell L. Hirschhorn & Brian Neulander, *ERISA's Statute of Limitations for Benefit Claims: Where To Begin?*, ERISA Litigation Newsletter, 4 (July 2010), http://www.proskauer.com/publications/newsletters/erisa-litigation-newsletter-july-2010/ ("In some contexts, particularly pension claims that are filed when a participant reaches retirement age, the claim itself may present issues that depend on information dating back to the participant's earlier years of active employment.").

Adoption of any implied provision other than a bright line at the clear and final denial of a benefit will undermine and frustrate both the Congressional determination that plans should have meaningful claims procedures and the uniform view of the federal courts that such procedures mandate exhaustion of the internal claims procedures.

III. AN IMPLIED REASONABLENESS TERM IS UNWORKABLE IN ERISA BENEFITS CASES BECAUSE IT IS STANDARDLESS, INCONSISTENT WITH ERISA'S NOTICE REQUIREMENTS, LEADS TO ABSURD RESULTS AND PROVIDES BOTH PLAN ADMINISTRATORS AND CLAIMANTS WITH INCENTIVES WHICH ARE AT ODDS WITH THE MANDATORY EXHAUSTION REQUIREMENT.

A. An Implied Reasonableness Term Is Subjective And Malleable.

Courts imply a reasonableness term into a contract when they have inadequate alternatives. ERISA cases do not present the Court with this dilemma.

An implied reasonableness term employed by courts in some circuits, and urged by Respondent in this case, fails to provide clarity, fair notice, or meaningful guidance to claimants and courts. Under this implied term, whether a plan's contractual accrual period may be enforced depends on whether the claimant had a reasonable time in which to file suit after completing the administrative process. *See*, *e.g.*, *Salisbury v. Hartford Life & Accident Co.*, 583 F.3d 1245, 1248-49 (10th Cir. 2009); *Abena v. Metro. Life Ins. Co.*, 544 F.3d 880, 884 (7th Cir. 2008); *Burke v. PriceWaterHouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 81 (2d Cir. 2009).

But reasonableness is a highly flexible concept, and courts "have no ready means of determining . . . how much 'compressing' of the plaintiff's limitations period was too "severe [ ]." *White v. Sun Life Assur. Co. of Can.*, 488 F.3d 240, 248-9 (4th Cir. 2007). If a reasonableness term is implied, claimants are left guessing whether a suit filed after the expiration of a contractual limitations period will be allowed. For example, in *Rotondi v. Hartford Life & Accident Grp.*, No. 09 Civ. 6287(PGG), 2010 WL 3720830, at *8 (S.D.N.Y. Sept. 22, 2010), the court concluded that a period of five months from final denial of the claim to the running of the plan's limitations period was fair, and granted summary judgment for the defendant on the ground that the suit was untimely. *Id.* In contrast, in *Hinojos v. Prudential Ins. Co. of Am.*, CIV. 10-1193 JH/LAM, 2011 WL 7768621 (D.N.M. Oct. 19, 2011), the contractual limitations period likewise expired five months after the conclusion of the administrative process, and the claimant filed suit thereafter. The court refused to dismiss the case as untimely, finding that it would be "unreasonable to deny Hinojos the benefit of ERISA's protection after he spent the time and effort exhausting his administrative remedies as ERISA requires." *Id.* at *7. This type of inconsistent adjudication is inevitable where the only standard governing court review is "reasonableness."

Moreover, "whether an accrual provision was 'reasonable' with respect to a particular claimant would change each day that the plan did not issue a final decision." *White,* 488 F.3d at 248. The longer the plan administrator takes to render a decision on

which the claimant can file suit, the less reasonable the accrual provision. Although this is arguably a check on the perverse incentives created by anything other than a bright-line rule that benefits claims accrue at final denial, discussed herein, *see supra* at 12-18 and *infra* at 23-25, it highlights that "reasonableness" is really no standard at all.

A reasonableness term is unpredictable in the extreme. For example, cases speak of situations where the plan might delay its decision until close to or after the contractual limitations has expired. *E.g.*, *Baptist Mem'l Hosp.--DeSoto, Inc. v. Crain Auto. Inc.*, 392 Fed. App'x. 288 (5th Cir. 2010). Is 30 days unreasonable when the plan intentionally delayed and reasonable when the plan did not? How much discovery will be required to determine the true motives of the plan administrator? What if the plan asks the claimant for more information and the claimant takes a long time to provide it? The mandatory appeal process is suspended during that time. See 29 C.F.R. § 2560.503-1(f)(4); § 2560.503-1(i)(4); *see also* Preamble to Final Rule of Claims Procedure, 65 Fed. Reg. 70,246, 70250, n.21 (Nov. 21, 2000). If the appeal period pushes right up against the limitations period, will it matter if the request was in good faith? Will it matter if the claimant's delayed response was due to sloth, disability or matters outside her control, such as her treating physician being on a vacation? Or part due to each?

An implied reasonableness term will not only undermine uniform administration of any given plan, it will undermine uniformity among the circuit courts

as similar fact patterns will result in different results.

B. An Implied Reasonableness Term Is Inconsistent With ERISA's Notice Requirements.

A capricious, shifting method of determining a benefit claim's accrual date is in direct tension with the statutory and regulatory framework, which emphasize the importance of notifying plan participants in writing of their rights.

ERISA requires plans to "be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). This Court has described this requirement as a "core functional requirement" ensuring that "every employee may, *on examining the plan documents*, determine exactly what his rights and obligations are under the plan." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995) (internal citations omitted) (emphasis in original). The pertinent Department of Labor regulations require written notification of any adverse benefit determination describing "the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action." 29 C.F.R. § 2560.503-1(g)(iv).

Adopting a reasonableness term is not faithful to the statutory purpose or the regulatory language. The limitations period may be written into the plan, but as noted, whether this period is enforceable is not

written into the plan, nor could it be, since it depends on the amount of time it takes to complete the administrative process. As a result, a participant cannot tell from the plan (or, indeed, from a notice of adverse benefit determination) how long he or she might have to file suit. The Fourth Circuit stressed this concern in *White*, noting:

> A sometimes-enforcing approach to accrual provisions would disregard the written plan requirement and make it impossible for plans to give their participants the notice of subsequent remedies required by law. . . . Contractual accrual periods like Sun Life's would be enforced sometimes, but not at other times, according to a standard neither contained in the plan document nor evident from its terms. Rather than apprising plan participants of their rights, the written plan would often mislead claimants by setting forth a purported time limitation that would, in reality, apply only if it satisfied a reasonableness analysis described nowhere in the plan.

White v. Sun Life Assur. Co. of Can., 488 F.3d 240, 248-9 (4th Cir. 2007); *accord*, *Price v. Provident Life & Accident Ins. Co.*, 2 F.3d 986, 988 (9th Cir. 1993) (statute of limitations is only triggered when participant learns of health benefit denial, regardless of plan language, due to ERISA's notice requirements).

Such an implied term undermines ERISA's policy to protect employee benefit rights by providing participants with "ready access to the Federal courts." *See* Section 2(b), 29 U.S.C. § 1001(b).

C. An Implied Reasonableness Term Can Lead To Absurd Results In Some Cases, Because It Is Divorced From The Purpose Of Limitations Periods And Accrual Provisions.

As is true in this case, many contractual limitations periods in ERISA disability plans accrue at the time "proof of loss" is provided to the plan. It makes no sense to enforce a contractual limitations provision when the claimant provides proof of loss and is found to be disabled under the plan, but benefits are later terminated because the claimant is found to no longer be disabled. This change in determination can take place many years after the initial proof of loss and already well beyond the limitations period. The reasonableness of the contractual accrual provision in such cases, depends on the duration of the disability, as determined by the plan administrator. Not surprisingly, courts have varied in their approach to this problem. *Compare Abena v. Metro. Life Ins. Co.*, 544 F.3d 880 (7th Cir. 2008) (enforcing a "proof of loss" accrual period despite plan administrator's approval of the claim for two years), *with Forrest v. The Paul Revere Life Ins. Co.*, 662 F. Supp. 2d 183 (D. Mass. 2009) (declining to enforce proof of loss accrual term when the plan administrator awarded two years of benefits). But regardless of outcome, this factual scenario

highlights a core problem with an implied reasonableness term: it is unmoored from the purpose of limitations periods and accrual rules.

Limitations periods, contractual or statutory, are meant to ensure that litigants do not sit on their rights, allowing evidence to become stale. *See, e.g.*, *Chase Secs. Corp. v. Donaldson*, 325 U.S. 304, 314 (1945); *Holmberg v. Armbrecht*, 327 U.S. 392, 396 (1946). Accrual rules are constructed around this purpose: a cause of action generally accrues when the affected party has a complete claim and can file suit. *See Bay Area Laundry & Dry Cleaning Pension Trust Fund v. Ferbar Corp. of Cal. Inc.*, 522 U.S. 192, 201 (1997). But under the reasonableness term proposed by Respondent and employed by some courts, a claimant who promptly pursues his administrative remedies and files suit within what would otherwise be considered a "reasonable" time – before any evidence becomes stale, after such remedies are exhausted and his claim is thus ripe for litigation – may still be barred by the plan's limitations period. In other words, the reasonableness of a contractual accrual period does not turn on whether the claimant diligently filed suit after his cause of action was complete. It turns on the simple number of months or years between exhaustion of administrative remedies and the expiration of the plan's limitations period. *See Abena*, 544 F.3d at 884 ("if the appeals process was so protracted that the claimant was *unable* to file suit within the contractual period, the application of this provision would not be reasonable") (emphasis added).

Only the bright-line rule that an ERISA benefits claim accrues when the administrative process is exhausted – and the claim is thus unquestionably ready for litigation – is consistent with the logical purpose behind statutes of limitations.

D. An Implied Reasonableness Term Provides The Wrong Incentives, Giving Plan Administrators An Incentive To Delay Resolution Of Claims And Claimants An Incentive To Rush Through The Administrative Process And File Premature Lawsuits.

Amici supports Petitioner's argument requiring an implied term to be read into the plan language, tolling any limitations period during a time a claimant is unable to bring suit. Respondent urges instead to adopt a case-by-case approach and asks the Court to read an implied exception to the plan language under certain circumstances. However, the utility and fairness of Respondent's approach depend on claimants filing lawsuits: if the administrative process continues until very close to or after the date on which the claimant would have to file suit under the plan's limitations provision, the claimant must either file suit prematurely, before exhausting the claim, or take the risk of pursing a lawsuit that is facially untimely. If a claimant is unaware that the limitations period might not be enforced by a court and thus does not attempt to litigate his claim, or cannot find a lawyer willing to spend hours litigating

the procedural issues of "reasonableness under these particular circumstances" question before even getting to the merits, his claim will simply be extinguished. Plan administrators, especially conflicted plan administrators, *see Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2350 (2008), knowing this, would have every incentive to delay resolution of claims as long as possible in the hopes that claimants will just go away. More sophisticated claimants have every incentive to rush through the administrative process or file suit before the administrative process is totally complete in order to preserve their rights. By using an implied reasonableness term, both outcomes are undesirable: claimants are meant to have a right to judicial review and the administrative process is meant to prevent unnecessary litigation. *See supra*, at 10-11, 12-18; *White v. Sun Life. Assur. Co. of Can.*, 488 F.3d 240, 248-9(4th Cir. 2007) ("Courts would be hard pressed to ascertain whether these [perverse] incentives caused a plan to delay a decision, despite the way in which such manipulation of the internal review process undermines both ERISA's civil remedy and internal appeals as mechanisms of 'full and fair review.').

CONCLUSION

For the foregoing reasons, the judgment below should be reversed, and the case remanded for further proceedings.

Dated: July 2, 2013

Respectfully submitted,

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