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 FOR RESPONDENTS

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QUESTION PRESENTED

Whether a court should enforce a contractual limitations provision in an ERISA disability benefits policy requiring that any suit be brought within three years after the date proof of loss is due, where the claimant had actual knowledge of the limitations period and more than a year to file suit within that period after the final administrative denial of her claim.

CORPORATE DISCLOSURE STATEMENT

Hartford Life and Accident Insurance Company is a wholly owned subsidiary of Hartford Life, Inc., which is a wholly owned subsidiary of Hartford Holdings, Inc., which is a wholly owned subsidiary of The Hartford Financial Services Group, Inc. The Hartford Financial Services Group, Inc. is a publicly traded corporation that has no parent corporation, and no publicly held corporation owns 10 percent of more of its stock.

Wal-Mart Stores, Inc. has no parent corporation, and no publicly held corporation owns 10 percent or more of its stock.

TABLE OF CONTENTS

TABLE OF CONTENTS—Continued

TABLE OF AUTHORITIES

CASES

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

STATUTES

TABLE OF AUTHORITIES—Continued

REGULATIONS

OTHER AUTHORITIES

TABLE OF AUTHORITIES—Continued

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BRIEF FOR RESPONDENTS

INTRODUCTION

Imagine a limitations provision in an ERISA plan requiring that any lawsuit challenging a denial of benefits be filed within one year after the final adverse decision. Petitioner does not dispute, and the United States effectively concedes (at 23 n.4), that such a provision would be valid. The provision at issue here permits suit up to three years after the claimant was required to submit proof of loss in support of her claim. The question presented is whether this three-year period is *un*enforceable—even though it gave petitioner *more* time to sue after the final adverse decision than

the one-year period would have allowed—because the three-year period ran from proof of loss, not from denial of the claim.

The answer must be determined by reference to ERISA's text and implementing regulations. Contracting parties may adopt a reasonable limitations provision and fix its duration, start date, and other features by agreement. As a matter of federal common law, such a provision is enforceable unless specifically prohibited by statute. ERISA, which protects the contractual terms upon which employers agree to provide benefits, contains no such prohibition. And although the Department of Labor's regulations closely govern the processing of benefit claims, they neither address nor prohibit the commonly used limitations provision at issue here. The provision is therefore enforceable, and it bars petitioner's claim.

Petitioner seeks a different result based not on ERISA's text or regulations, but on two principles she contends should be read into ERISA's silence. One principle derives from a rule of statutory interpretation this Court has applied to statutes of limitations that run from the time a cause of action "accrues." The other derives from ERISA's remedial scheme. Petitioner's reliance on each of these principles fails on its own terms. But a broader point also requires their rejection: Petitioner asks this Court to rewrite or ignore a plan term based on no more than a sense that the term seems "'odd'" or potentially inconsistent (in theory, though not in practice) with notions of fair remedial policy. Categorical invalidation of plan terms on such a basis would upend parties' reasonable reliance interests and defeat the purposes of ERISA's written plan requirement. That result would be particularly unwarranted here, where most States require insurance poli-

cies to include the limitations provision, where similar provisions have been widely used for decades without prejudicing diligent claimants, and where petitioner has never explained why she could not have filed her lawsuit years earlier.

STATEMENT

A. Hartford's Group Disability Insurance Policy

1. Disability insurance helps replace lost income for employees who become unable to work due to injury or illness. Many employers voluntarily offer disability insurance as a benefit to employees by purchasing a group disability insurance policy. In this case, respondent Wal-Mart provided disability benefits to its employees under a group insurance policy (the Policy) issued by respondent Hartford.

Under the Policy, Hartford pays benefits to qualifying Wal-Mart employees who become "totally disabled." As relevant here, the Policy defines "total disability" as an employee's inability, due to certain medical conditions, to perform the essential duties of her occupation. Opp. App. 2a. Hartford has discretion to determine a claimant's eligibility for benefits. CAJA34. To do so, it needs information about the claimant's medical condition and functionality, such as physician reports, medical records, or work history. An employee who has applied for benefits must therefore submit "proof of loss" describing the nature of the claim and substantiating her eligibility for benefits. Proof of loss is due "within 90 days after the start of the period for which The Hartford owes payment." Opp. App. 5a.[1]

[1] Benefits for total disability become payable the day after a waiting period known as the "Elimination Period." Opp. App. 3a-

Hartford may also request other information from the claimant or from her physicians.

If Hartford denies a claim, the claimant may administratively appeal. Opp. App. 6a. If Hartford upholds the denial of benefits on appeal, the claimant may file a civil action challenging the denial of benefits under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132(a).

The provision of the Policy at issue here sets time limits for a claimant to bring such a suit. The Policy provides:

> Legal action cannot be taken against The Hartford:
>
> (1) sooner than 60 days after due proof of loss has been furnished; or
>
> (2) after the shortest period allowed by the laws of the state where the policy is delivered. This is 3 years after the time written proof of loss is required to be furnished according to the terms of the policy.

Opp. App. 7a.

2. Limitations provisions requiring suit to be brought within a certain period after proof of loss is due have long been a common feature of disability and health insurance policies. Like any limitations provision, a contractual limitations provision in an insurance

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4a. As relevant here, the Elimination Period ends, and benefits become payable, when the employee has been totally disabled for 90 days or when Wal-Mart stops making salary continuation payments, whichever is later. Opp. App. 1a; Pet. App. 9.

policy assures fairness to defendants by "prevent[ing] fraudulent and stale claims from springing up at great distances of time." 16 *Couch on Insurance 3d* § 234:4 (2005) ("*Couch*"). Those interests are acute for insurers, who must be able to anticipate the timing and volume of claims for reserving and rate-setting purposes.

Insurance policies thus typically provide that any action must be commenced within a certain period of time after the insured loss, or the "inception of the loss," or the date by which "notice" or "proof of loss" is required. The standard fire insurance policy, for example, long required that any suit be commenced within 12 months "after the fire." *E.g.*, Darrach, *The Standard Fire Insurance Policy* 19 (1905); Jerry, *Understanding Insurance Law* § 85[b] ("Jerry"). Similarly, the limitations period for life insurance claims is "generally … triggered by the death of the insured." 17 *Couch* § 236:30. And property insurance suits must typically commence within a certain period after the "date of the loss." *Id.* §§ 236:12, 236:22. Each of these formulations ties the start of the limitations period to the insured event (or something close to it), ensuring that any litigation will not be too remote in time from the events giving rise to the claim.

Disability and health policies have long included similar terms. For a century, the model laws of the National Association of Insurance Commissioners (NAIC) and its predecessor have required certain accident and health policies to include a limitations period running from the proof-of-loss deadline. *See* Uniform Individual Policy Provisions Law Model Bill of 1950, § 3(A)(11), *reprinted in* Meyer, *Life and Health Insurance Law* app. A, 860 (1971) (no action "after the expiration of three years after the time written proof of loss is required to be furnished"); Uniform Standard Provision

Bill of 1912, § 3(14), *reprinted in Proceedings of the National Convention of Insurance Commissioners* 123 (1912) (no action "unless brought within two years from … the time within which proof of loss is required"). NAIC's current model law for group accident and health insurance continues to require a provision that "no action shall be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the policy." Group Health Insurance Standards Model Act § 8(N), *reprinted in* NAIC, *Model Laws, Regulations and Guidelines* (2012).

The "vast majority" of States have adopted the NAIC model by "requir[ing] insurance contracts to include the proof of loss limitations language." *Burke* v. *PriceWaterhouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 81 (2d Cir. 2009) (per curiam); *see also Wetzel* v. *Lou Ehlers Cadillac Group Long Term Disability Ins. Program*, 222 F.3d 643, 647 n.5 (9th Cir. 2000) (en banc) (listing statutes). As a nationwide insurer doing business in all 50 States, Hartford's policy language must, and does, conform to these state laws.[2]

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[2] The state laws all require a limitations provision running from the time proof of loss is due. They vary in the types of accident and health policies covered; in whether the insurer may seek approval to adopt a different period; and in the length of the limitations period. In addition to the 43 state laws identified in *Wetzel*, see also Fla. Stat. §§ 627.616, 627.657(3), 627.660(3)-(4); La. Rev. Stat. §§ 22:975(A), 22:986(B); N.D. Cent. Code § 26.1-36-05; Va. Code Ann. § 38.2-3540. Maryland law prohibits the enforcement of a limitations period shorter than that required by the State where the policy was issued or delivered. *See* Md. Ins. Code Ann., § 12-104(a). Utah and Wisconsin, rather than making the proof-of-loss limitations period a mandatory policy provision, provide statutes of limitations requiring suits on disability coverage to be brought

B. Ms. Heimeshoff's Disability Claim

Petitioner Julie Heimeshoff began working for Wal-Mart in 1986 and eventually became eligible for Wal-Mart's group disability plan. Pet. App. 6. On August 22, 2005, Ms. Heimeshoff submitted a claim for long-term disability benefits, asserting that she could no longer work due to pain and fatigue. Pet. App. 7. Ms. Heimeshoff supported her application with a statement by her rheumatologist, who diagnosed lupus and fibromyalgia. *Id.*

According to the terms of the Policy, Ms. Heimeshoff was required to submit proof of loss by December 8, 2005.[3] Throughout September and October 2005, Hartford obtained medical records, collected information about her work duties, and interviewed Ms. Heimeshoff about her condition. To determine whether Ms. Heimeshoff met the Policy's definition of "total disability," however, Hartford also needed information regarding her functionality and whether she could perform sedentary work. Hartford accordingly sent several faxes in October and November 2005 to the rheumatologist Ms. Heimeshoff had identified as her attending physician requesting that information. JA6. Those requests went unanswered. On November 21, 2005, Hartford sent another request to the rheumatologist

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within three years after proof of loss is due, Wis. Stat. § 631.83(1)(b), or three years after inception of the loss, Utah Code Ann. § 31A-21-313(1).

[3] Ms. Heimeshoff stopped working on June 8, 2005. Pet. App. 6. Because Wal-Mart continued paying her salary through September 8, 2005, *see* CAJA126; Pet. App. 7, the Elimination Period ended on that day, and any benefits owed would have become payable the next day, September 9, 2005. Ms. Heimeshoff's proof of loss was due 90 days later, on December 8, 2005.

and wrote to Ms. Heimeshoff, urging her to have her doctor return the requested information. JA6-8. Ms. Heimeshoff did not respond. Hartford wrote to her again on November 29, 2005, explaining that it still had not received the requested information and that it "c[ould] not make a claim decision without this information." JA9-10. Ms. Heimeshoff again failed to provide the information. Pet. App. 7-8; JA13-14.

On December 8, 2005, Hartford denied Ms. Heimeshoff's claim for "failure to 'provide satisfactory Proof of Loss.'" Pet. App. 8; *see* JA11-15. Hartford explained that it could not determine whether Ms. Heimeshoff was "totally disabled" within the meaning of the Policy without the information it had requested about her functionality, but stated that it would consider that information if she submitted it as soon as possible. JA13-14. Hartford also advised Ms. Heimeshoff of her right to appeal by submitting a written request for review within 180 days. JA14.

Five months later, Ms. Heimeshoff obtained counsel. Pet. App. 8. On May 18, 2006, Ms. Heimeshoff's counsel wrote to Hartford to confirm her intent to appeal and to request an additional 180 days in which to "submit additional information in support of [her] claim." JA17, 19. Counsel also requested a copy of the Policy and the administrative record. *Id.* On May 31, 2006, Hartford provided the requested materials, including the Policy, which stated the three-year limitations period. In its cover letter, Hartford reiterated that it had not denied Ms. Heimeshoff's claim based on a finding that she was not "totally disabled," but that it had been unable to determine whether she qualified for benefits without the requested information about her functionality. JA20-21. Given that circumstance, Hartford explained that it would reopen Ms. Heimeshoff's

claim without any need for a formal appeal if it received the information it had previously requested. *Id.* In subsequent correspondence, Hartford clarified that Ms. Heimeshoff could choose either to submit the requested information to reopen her claim without appealing or proceed with an appeal immediately. App. 10a. Ms. Heimeshoff elected to reopen her claim and sought a further extension of time to do so. App. 12a-13a.[4]

On October 2, 2006, Ms. Heimeshoff submitted additional information, including physician reports and the results of a physical capacity evaluation. Pet. App. 8. Hartford retained an independent rheumatology consultant and reopened Ms. Heimeshoff's claim as requested. Pet. App. 9; JA25.[5] On November 29, 2006, Hartford notified Ms. Heimeshoff of its determination that she did not meet the definition of "total disability." JA22-27. Hartford explained that its consultant had reviewed all the information in the file and concluded that Ms. Heimeshoff "'was able to physically perform the activities of her sedentary occupation.'" JA25. Hartford noted among other things that "[e]xams, including [by] a team of physicians at the Mayo Clinic, have consistently revealed no exam findings except for tender points." JA25. Hartford again advised petitioner of her right to appeal by submitting a request for re-

[4] This correspondence, reproduced in the Appendix to this brief, was part of the claim file that Ms. Heimeshoff "incorporate[d]" into her complaint "as if annexed [t]hereto." JA61 n.1; *see* Pet. App. 10-12.

[5] The Brief in Opposition mistakenly stated (at 5) that Hartford's consultant spoke with Ms. Heimeshoff's rheumatologist. In fact, the rheumatologist refused to speak to Hartford's consultant by phone and failed to respond to a follow-up letter. JA25.

view within 180 days and of her "right to bring a civil action under Section 502(a) of ERISA." JA26-27.

Nearly 180 days later, on May 24, 2007, Ms. Heimeshoff sought an extension of time to appeal until September 30, 2007. Pet. App. 14; JA28-29. Hartford agreed. Pet. App. 14-15. On September 26, 2007, Ms. Heimeshoff submitted her appeal, JA32-49, and Hartford began an administrative review with the assistance of two new physician-consultants, Pet. App. 9.[6] At the end of that review, on November 26, 2007, Hartford concluded again that Ms. Heimeshoff was not "totally disabled" and upheld the denial of her claim. Pet. App. 9; *see* JA50-59. Hartford explained that, after a detailed review, Hartford's new rheumatology consultant agreed that Ms. Heimeshoff "retain[ed] the residual physical capacity to perform sedentary work, and therefore ha[d] the work capacity to perform her occupation." JA52. Hartford's consulting neuropsychologist also explained that the "available data … d[id] not indicate restrictions or limitations." JA56. Hartford concluded that "the weight of the medical and vocational evidence in our file" indicated that Ms. Heimeshoff "is able to perform at least sedentary full time work and [that] her own occupation is identified within that capacity. Because she is employable in her own sedentary work, she is not disabled and the decision to deny [long-term disability] benefits was correct under the terms of the policy." JA58.

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[6] Ms. Heimeshoff's appeal materials included a note from her rheumatologist "declin[ing] Hartford's request" to provide any information about her functionality, "as that [wa]s outside his specialty." JA40.

C. This Litigation

For nearly three years, Ms. Heimeshoff took no further action. On November 18, 2010—nearly five years after the proof-of-loss deadline—Ms. Heimeshoff filed this action against Hartford and Wal-Mart, alleging that Hartford abused its discretion in denying her claim. JA60-83. She was represented by the same law firm that handled her administrative appeal four-and-a-half years earlier, *compare* JA16, *with* JA60, and the complaint rested solely on information in the administrative record or on "information and belief," JA60-83.

Respondents moved to dismiss the complaint as untimely under the Policy's limitations provision, and the district court granted the motion. Pet. App. 5-6. The court explained that the Policy "unambiguously disallows legal action more than three years after the time written proof of loss is required to be furnished." Pet. App. 15. Even crediting Ms. Heimeshoff's argument that proof of loss was not due until September 30, 2007—the date of the extension Hartford had agreed to for her administrative appeal, *supra* p. 10—the district court held that Ms. Heimeshoff's suit was untimely. Pet. App. 15.[7] The court also rejected Ms. Heimeshoff's

[7] The parties disputed below whether Hartford's agreement to extend the deadline for the administrative appeal altered the proof-of-loss deadline. As Hartford explained, the Policy gave Ms. Heimeshoff until December 8, 2005 to submit proof of loss. Although an insurer's demand for new or additional proof of loss could reset the proof-of-loss deadline in some circumstances, that did not occur where Hartford merely allowed Ms. Heimeshoff more time to appeal. Resp. C.A. Br. 8-11, 29-32. Even under Ms. Heimeshoff's view, however, the latest date proof of loss could have been due was September 30, 2007. This suit was filed more than three years after that date. Pet. App. 15.

argument that Hartford's failure to state the limitations provision in its letters denying her claim precluded Hartford from enforcing the time bar. Pet. App. 15-18. Interpreting ERISA's implementing regulations, the court held that "Hartford was not required to inform Ms. Heimeshoff of the [Policy]'s limitations period for legal action in its benefits determination letter." Pet. App. 17-18.

On appeal, Ms. Heimeshoff argued primarily that Hartford should be precluded from enforcing the limitations provision, or that the period should be equitably tolled, because Hartford's denial letters had not stated the time limits for filing suit. Pet. C.A. Br. 12-36, 47-51. In the alternative, Ms. Heimeshoff argued that the limitations period could not begin to run until Hartford denied her administrative appeal because her cause of action did not accrue until she exhausted her administrative remedies. *Id.* at 37-44.

The court of appeals rejected both arguments and affirmed. Pet. App. 1-4. Noting that "federal law controls the accrual date of [a] party's claim," the court relied on circuit precedent holding that "it does not offend [ERISA] to have the limitations period begin to run before the claim accrues." Pet. App. 3 (citing *Burke*, 572 F.3d at 81). Applying the Policy's limitations provision as written, the court held that Ms. Heimeshoff's action was time-barred because she filed it "more than three years after her proof of loss was due." *Id.*

The court also refused to apply equitable tolling. The court noted that Ms. Heimeshoff's counsel conceded he had received a copy of the Policy containing the limitations provision "long before the three-year period … had expired." Pet. App. 4. In light of Ms. Heimeshoff's actual knowledge of the time limits for

suing, she was "not entitled to equitable tolling," regardless whether Hartford had provided inadequate notice in its denial letters. *Id.*

SUMMARY OF ARGUMENT

The Policy's limitations provision is enforceable because nothing in ERISA's text or implementing regulations prohibits it. This Court has long held that contracting parties may design and adopt a reasonable limitations period to govern their agreement and that such a provision is enforceable "absen[t] … a controlling statute to the contrary." *Order of United Commercial Travelers of Am.* v. *Wolfe*, 331 U.S. 586, 608 (1947). That principle dovetails with ERISA's singular focus on contractually defined benefits, which likewise requires that the terms upon which an employer agreed to provide benefits shall govern unless they violate a specific prohibition or requirement in the statute or regulations. Under these controlling rules, the absence of any provision in ERISA or its regulations prohibiting enforcement of the Policy's commonly used limitations provision is dispositive.

Ms. Heimeshoff's efforts to overcome ERISA's silence take two tacks, neither of which succeeds. First, she contends that ERISA incorporates a background "rule" of federal law—one which parties may never contract around—that the limitations period on a federal cause of action cannot run from a point in time different from the point when the plaintiff has a complete and present cause of action. The rule Ms. Heimeshoff cites, however, is a default rule of statutory interpretation courts have invoked to identify the time of "accrual" when a statute of limitations runs from the time a cause of action "accrues." That rule has no bearing on provisions that key the start of the limitations period to

a date other than "accrual" of the cause of action. And it does not address, much less restrict, the terms parties may choose when adopting a limitations provision by contract.

Second, Ms. Heimeshoff asserts that the limitations provision violates ERISA's remedial scheme because the provision *might* leave a claimant with too little time to sue, or *might* frustrate the internal review process in rare cases. That speculation is baseless. Although this limitations provision has been in widespread use throughout ERISA's lifetime, neither Ms. Heimeshoff nor the United States cites *any* evidence that the harms they fear have occurred in any kind of systemic way. That is not surprising. Regulatory deadlines governing the administrative review process, combined with the generous length of the limitations period, make it virtually impossible for the internal review to consume a claimant's time for seeking judicial review.

If enforcement of the limitations provision ever actually resulted in unfair prejudice to a diligent claimant, a court would address that circumstance by applying the same tools courts have always applied in conjunction with statutes of limitations—estoppel and waiver, equitable tolling, and the reasonableness requirement. Those tools are adequate to ameliorate any unfairness that might arise in exceptional cases, while respecting the terms of the plan. Contrary to Ms. Heimeshoff's contention, allowing for case-specific adjustment on the rare occasions it is necessary does not rewrite or cloud the meaning of the Policy's limitations provision any more than it does when applied to an ordinary statute of limitations.

Every court of appeals but one to have considered the question has thus concluded that nothing in

ERISA's remedial scheme precludes enforcement of the proof-of-loss limitations provision, which has coexisted with ERISA for decades. *See* Opp. 12-17. If the Department of Labor nonetheless concluded that the provision is too "'odd'" or inconsistent with ERISA policy, the Department could seek to regulate its use. It has not done so, however, despite closely regulating the procedures for resolving benefit claims. Where the Department has chosen not to act, the Court should not craft a wholesale rule invalidating or suspending the plan term—particularly in a case where the claimant failed to exercise due diligence and the provision's enforcement was perfectly reasonable.

ARGUMENT

I. A Reasonable Limitations Provision In An ERISA Plan Should Be Enforced As Written

This Court has long held that contractual limitations provisions are enforceable unless unreasonable or specifically prohibited by statute. *See Order of United Commercial Travelers of Am.* v. *Wolfe*, 331 U.S. 586, 608 (1947); *Riddlesbarger* v. *Hartford Insurance Co.*, 74 U.S. (7 Wall.) 386 (1868). That principle fits hand-in-glove with ERISA's "purpose to protect contractually defined benefits," *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 148 (1985), and it dictates the proper analysis of this case. Ms. Heimeshoff has never contended, and could not contend, that the limitations provision in Hartford's Policy is facially unreasonable or left her with inadequate time to sue. The provision is therefore enforceable unless ERISA specifically prohibits it. But ERISA's text is silent on the subject. It does not supply a limitations period and does not prohibit parties from adopting one. And although the implementing regulations closely govern procedures for

resolving benefit claims—including exhaustion and timing requirements—they neither address nor preclude enforcement of the ubiquitous proof-of-loss limitations provision.

A. Contracting Parties May Agree To A Reasonable Limitations Period, And Such Provisions Are Enforceable Unless Specifically Prohibited

1. Statutes of limitations "encourage promptness in the bringing of actions" so that "the parties shall not suffer by loss of evidence from death or disappearance of witnesses, destruction of documents, or failure of memory." *Missouri, Kan., & Tex. Ry. Co.* v. *Harriman Bros.*, 227 U.S. 657, 672 (1913). By "assur[ing] fairness to defendants," *Burnett* v. *New York Cent. R.R. Co.*, 380 U.S. 424, 428 (1965), limitations periods also serve the "general interest of the public," 1 Corman, *Limitations of Actions* §1.1 (1991):

> Judicial efficiency is the reward when these statutes produce speedy and fair adjudication of the rights of the parties. Certainty and finality in the administration of affairs is promoted, and courts are relieved of the burden of trying stale claims when plaintiffs have 'slept' on their rights.

See also Gabelli v. *SEC*, 133 S. Ct. 1216, 1221 (2013); *United States* v. *Kubrick*, 444 U.S. 111, 117 (1979).

Consistent with these salutary purposes and with the freedom of contract, courts have long held that contracting parties may include a limitations provision in their agreement and that such provisions are enforceable unless unreasonable or specifically prohibited by statute. *Wolfe*, 331 U.S. at 608; *see also Leigh Ellis &*

Co. v. *Davis*, 260 U.S. 682, 688-689 (1923); *Thompson* v. *Phenix Ins. Co.*, 136 U.S. 287, 298 (1890); *Riddlesbarger*, 74 U.S. (7 Wall.) at 390. Parties adopting such provisions are not bound by the terms of the otherwise-applicable statute of limitations. The purpose of a statute of limitations is simply "'to encourage promptitude in the prosecution of remedies'" by establishing a deadline beyond which liability is cut off and the defendant may find repose. *Wolfe*, 331 U.S. at 608 n.20. Nothing in that purpose "'inhibits parties from stipulating for a shorter period within which to assert their respective claims.'" *Id.*

The right to "stipulat[e] for a shorter period" reflects the general freedom of contracting parties to agree to terms of their choosing. As this Court explained in enforcing an insurance policy term requiring suit to be commenced within 12 months after the loss, "[t]he contract of insurance is a voluntary one." *Riddlesbarger*, 74 U.S. (7 Wall.) at 390. Insurers therefore "have a right to designate the terms upon which they will be responsible for losses." *Id.* "It is clearly for the interest of insurance companies that the extent of losses sustained by them should be speedily ascertained, and it is equally for the interest of the assured that the loss should be speedily adjusted and paid." *Id.* Therefore, "it is not an unreasonable term" to require suit "whilst the transaction is recent, and the proofs respecting it are accessible." *Id.*; *see also Wolfe*, 331 U.S. at 599 (upholding insurance provision requiring suit within six months after claim is disallowed).

As the United States concedes (at 16-17), this freedom-of-contract principle applies as a matter of federal common law in suits to enforce federal statutory

rights.[8] This Court has invoked the principle, for example, to uphold a 90-day limitations provision in an interstate shipping contract in a suit under the Carmack Amendment to the Hepburn Act. *Harriman Bros.*, 227 U.S. at 672-673. The Court evaluated the validity of the limitations period as "a Federal question to be determined under the general common law," and enforced it because it was reasonable. *Id.* at 672; *see also Louisiana & W.R. Co.* v. *Gardiner*, 273 U.S. 280, 283 (1927); *Texas & Pac. Ry. Co.* v. *Leatherwood*, 250 U.S. 478, 481-482 (1919). Courts have applied the same principle to enforce contractual limitations provisions in a host of other federal contexts. *See, e.g.*, *Cange* v. *Stotler & Co.*, 826 F.2d 581, 583-584 (7th Cir. 1987) (Commodity Exchange Act); *Farris* v. *Celebrity Cruises, Inc.*, 487 F. App'x 542, 543-544 (11th Cir. 2012) (maritime suit); *Entous* v. *Viacom Int'l, Inc.*, 151 F. Supp. 2d 1150, 1155-1156 (C.D. Cal. 2001) (Copyright Act); *Reichhold Chems., Inc.* v. *United States*, 11 Cl. Ct. 150, 152-153 (1986) (government contract).

2. In "designat[ing] the terms upon which they will be responsible for losses," *Riddlesbarger*, 74 U.S. (7 Wall.) at 390, contracting parties may specify not only the length of the limitations period, but also its other features. For example, a contractual limitations provi-

[8] The enforceability of the Policy's limitations provision under ERISA is a federal question. Ms. Heimeshoff claims (at 30) the court of appeals upheld the provision on the ground that "*state law* permitted alteration of accrual dates." But the court specifically acknowledged that "federal law controls" the issue. Pet. App. 3. And the precedent relied on by the court of appeals analyzed the provision in light of ERISA, *see Burke* v. *PriceWaterhouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 80-81 (2d Cir. 2009) (per curiam), noting only in passing that state law independently allowed the provision, *id.* at 78-79.

sion may relieve the parties of exceptions found in the otherwise-applicable statute of limitations. *Id.* at 391; *see also Chichester* v. *New Hampshire Fire Ins. Co.*, 51 A. 545, 546-547 (Conn. 1902). Parties may alter the date on which a suit is considered filed for purposes of satisfying the limitations period. *See J. Aron & Co.* v. *The Askvin*, 267 F.2d 276, 277 (2d Cir. 1959) (per curiam). And in *Thompson*, this Court recognized the validity of a waiting-period provision in an insurance policy barring any suit before "60 days had elapsed after the receipt of the proofs of loss." 136 U.S. at 292.

It follows that just as parties can alter the length and other features of the limitations period, they can also choose the starting point from which the limitations period is measured. *See, e.g.*, *International Union of Elec., Radio & Mach. Workers, Local 790* v. *Robbins & Myers, Inc.*, 429 U.S. 229, 234 (1976) ("parties could conceivably have agreed to a contract" making certain conduct the "relevant statutory 'occurrence'" triggering the start of the limitations period). For example, parties may contract to avoid application of the discovery rule, which would otherwise delay the running of the limitations period until a time when the plaintiff knew or should have known of the wrong. *Harbor Ct. Assocs.* v. *Leo A. Daly Co.*, 179 F.3d 147, 149 (4th Cir. 1999). Similarly, federal courts have applied limitations provisions in bills of lading running from the date "the loss occurred," *Leatherwood*, 250 U.S. at 479; "'delivery of the property,'" *Leigh Ellis & Co.*, 260 U.S. at 688; "the giving of written notice" of the loss, *Schnell* v. *United States*, 30 F.2d 676, 677 (2d Cir. 1929); *see also The Turret Crown*, 284 F. 439, 441 (4th Cir. 1922); and "written disallowance of a claim for loss," *North Am. Phillips Corp.* v. *Emery Air Freight Corp.*, 579 F.2d 229, 234 (2d Cir. 1978). And federal

courts have enforced insurance contract provisions requiring suit within twelve months from the date of "the loss," *Riddlesbarger*, 74 U.S. (7 Wall.) at 389; six months from "the date the claim … is disallowed," *Wolfe*, 331 U.S. at 599; three years from the date "'written Proof of Loss is required to be furnished,'" *Matthew* v. *Unum Life Ins. Co. of Am.*, 639 F.3d 857, 866 (8th Cir. 2011); and two years from "'the date you were first sent a notice of the service or claim denial,'" *Island View Residential Treatment Ctr.* v. *Blue Cross Blue Shield of Mass., Inc.*, 548 F.3d 24, 27 (1st Cir. 2008).

Many insurance policies that include limitations provisions running from the time of the "loss" (or something close to it) also preclude suit until the insurer has decided the claim. *See, e.g.*, *Madi* v. *Modern Woodmen of Am.*, 167 P. 1083, 1084-1085 (Wash. 1917) (18-month limitation provision in life insurance certificate commenced upon "the date of the death," notwithstanding policy language precluding suit until insurer decided the claim); *Proc* v. *Home Ins. Co.*, 217 N.E.2d 136, 139 (N.Y. 1966) (12-month limitation provision in fire insurance policy ran "from the date of the fire, even though a cause of action against the insurer had not then accrued").[9] Referring to such a policy, this Court recognized in *Wolfe* that the parties' freedom to adopt a reasonable limitations provision permitted enforcement of "a clause in a fire insurance policy providing that no ac-

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[9] *See also, e.g.*, *Rottier* v. *German Ins. Co. of Freeport, Ill.*, 86 N.W. 888, 889 (Minn. 1901); *Simms* v. *Allstate Ins. Co.*, 621 P.2d 155, 156-157 (Wash. Ct. App. 1980); *Adams* v. *Northern Ins. Co. of N.Y.*, 493 P.2d 504, 507 (Ariz. Ct. App. 1972); 17 *Couch* § 236:30 (limitations period on life insurance claims "generally … triggered by the death of the insured, not when the claim is rejected and the action accrues").

tion for recovery of any claim shall be sustainable in any court unless commenced within six months after the fire itself, even though such actions were prohibited during most of the first three of those months." 331 U.S. at 610.

Thus, as Ms. Heimeshoff concedes (at 12), policies commonly include a 60-day waiting period that must elapse before a policyholder may file suit. *See FDIC* v. *Hartford Accident & Indem. Co.*, 97 F.3d 1148, 1149-1151 (8th Cir. 1996). The waiting period allows the insurer time to decide whether to pay the claim and requires the claimant to submit proof of loss and await the insurer's decision while the limitations provision is running. *See, e.g.*, *Chambers* v. *Atlas Ins. Co.*, 51 Conn. 17, 1883 WL 1583, at *2 (1883) ("The contract keeps the day upon which a fire shall occur entirely distinct from the day upon which the right to sue for indemnity accrues[.]"); *Appel* v. *Cooper Ins. Co.*, 80 N.E. 955, 957-958 (Ohio 1907) (presentation of proof of loss and expiration of waiting period are conditions precedent to suit that must be completed within the limitations period); *Wever* v. *Pioneer Fire Ins. Co.*, 153 P. 1146, 1147-1149 (Okla. 1915) (same); *John Morrell & Co.* v. *New England Fire Ins. Co.*, 44 A. 358, 358-359 (Vt. 1899) (same). Like any other contractual limitations term, such provisions reflect the contracting insurer's "right to designate the terms upon which they will be" liable and are enforceable if reasonable and not specifically prohibited. *Riddlesbarger*, 74 U.S. (7 Wall.) at 390.

Ms. Heimeshoff has never contended that the time allowed under Hartford's Policy is "unreasonably short" on its face. *Harriman Bros.*, 227 U.S. at 672. Nor could she, given the provision's ubiquity and historical roots and the prevalence of equivalent or shorter limitations periods throughout the U.S. Code. *See*

Jerry § 85[a] ("Almost uniformly, courts have held contractual limitations periods as short as one year to be reasonable in length."). As the United States concedes, this reasonable provision is therefore enforceable "'in the absence of a controlling statute to the contrary.'" U.S. Br. 17 (quoting *Wolfe*, 331 U.S. at 608). The Court found such a controlling statute in *Gardiner*, where a bill of lading requiring suit within two years and one day after delivery was held invalid in the face of a federal statute "declar[ing] unlawful any limitation shorter than two years from the time notice is given of the disallowance of the claim." 273 U.S. at 284; *see also Leatherwood*, 250 U.S. at 480 n.1. Absent a similar command in ERISA, the reasonable limitations period in Hartford's Policy is enforceable.

B. ERISA Requires Enforcement Of Plan Terms Unless Prohibited

The principle that a reasonable contractual limitations provision should be enforced as written "fits lock and key with ERISA's focus on what a plan provides." *US Airways, Inc.* v. *McCutchen*, 133 S. Ct. 1537, 1548 (2013). ERISA protects "contractually defined benefits," *Russell*, 473 U.S. at 148, and incorporates freedom-of-contract concepts. As this Court has recognized, ERISA neither "'requires employers to establish employee benefit plans'" nor "'mandate[s]'" the benefits employers provide. *Black & Decker* v. *Nord*, 538 U.S. 822, 833 (2003); *see also Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 79 (1995). "Rather, employers have large leeway to design disability and other welfare plans as they see fit." *Black & Decker*, 538 U.S. at 833; *see also Rice* v. *Jefferson Pilot Fin. Ins. Co.*, 578 F.3d 450, 455 (6th Cir. 2009) ("We have specifically emphasized the freedom of parties to contract for the de-

tails of ERISA claims[.]"); *Northlake Reg'l Med. Ctr.* v. *Waffle House Sys. Emp. Benefit Plan*, 160 F.3d 1301, 1303 (11th Cir. 1998) ("An ERISA plan is nothing more than a contract, in which parties as a general rule are free to include whatever limitations they desire.").

Encouraging employers to offer welfare plans is one of ERISA's central goals. *See Aetna Health, Inc.* v. *Davila*, 542 U.S. 200, 215 (2004) (citing *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 55 (1987)); *see also Conkright* v. *Frommert*, 130 S. Ct. 1640, 1648-1649 (2010). To that end, "Congress sought 'to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.'" *Conkright*, 130 S. Ct. at 1649 (quoting *Varity Corp.* v. *Howe*, 516 U.S. 489, 497 (1996)). Rather, "ERISA 'induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Id.* (quoting *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 379 (2002)).

ERISA delivers that predictability through the promise that a plan will be enforced as written. The statutory scheme "'is built around reliance on the face of written plan documents.'" *McCutchen*, 133 S. Ct. at 1548. It requires fiduciaries, claimants, and courts to "hew[] to" the contractual "plan documents" as written. *Kennedy* v. *Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 300 (2009). "Every employee benefit plan shall be established and maintained pursuant to a written instrument," 29 U.S.C. § 1102(a)(1), and a fiduciary must act "in accordance with the documents and instruments governing the plan," so long as they are consistent with the statute and regulations, *id.*

§ 1104(a)(1)(D). Section 1132(a)(1)(B) thus authorizes suit to "recover benefits due … *under the terms of* [*the*] *plan*, to enforce … rights *under the terms of the plan*, or to clarify … rights to future benefits *under the terms of the plan*." *Id.* § 1132(a)(1)(B) (emphases added). "The [written] plan, in short, is at the center of ERISA." *McCutchen*, 133 S. Ct. at 1548.

This Court has accordingly refused to rewrite or ignore plan terms to achieve policies or satisfy requirements that do not appear in ERISA's text or implementing regulations. As the United States has observed, "[i]t would be inconsistent with Congress's judgment generally eschewing regulation of the substantive content of ERISA plans" to give courts authority "not to enforce the terms of the plan as written." U.S. Br. 13, *US Airways* v. *McCutchen*, No. 11-1285 (U.S. Sept. 5, 2012). In *Kennedy*, for example, the Court refused to craft a "federal common law of waiver" for divorce decrees that waive a divorced spouse's benefits but fail to comply with the procedures outlined in the written plan. 555 U.S. at 303. Such a waiver "might obscure a plan administrator's duty to act 'in accordance with the [plan] documents and instruments.'" *Id.* (quoting *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 259 (1993)). Similarly, in *Black & Decker*, the Court declined to subject a plan to a judicially crafted treating-physician rule where nothing in the statute or regulations required plan fiduciaries to defer to the opinions of treating physicians. 538 U.S. at 829-834. Reading such a requirement into the statute would have undermined ERISA's goal of allowing employers to "design … plans as they see fit." *Id.* at 833.

Even in the equitable context of a Section 1132(a)(3) suit, this Court held in *McCutchen* that courts had no authority to deviate from the "clear

terms of a plan." 133 S. Ct. at 1543. The United States doubts *McCutchen*'s relevance (at 18 n.3) because it involved an action analogous to enforcement of an "equitable lien by agreement," but that reasoning is backwards: If anything, a suit for "benefits due … under the terms of [the] plan," 29 U.S.C. § 1132(a)(1)(B), is *more* tightly constrained by the terms of the plan than a suit for equitable relief under Section 1132(a)(3). "The statutory language [of Section 1132(a)(1)(B)] speaks of '*enforc[ing]*' the 'terms of the plan,' not of *changing* them." *CIGNA Corp.* v. *Amara*, 131 S. Ct. 1866, 1876-1877 (2011).[10]

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[10] The United States (at 24-25) mentions trust law, but no trust-law principle justifies rewriting or ignoring the settlor's intentions as expressed in the trust documents. And even if it were correct to analogize a final denial of benefits to a trust beneficiary's receipt of an accounting revealing the existence of a claim—a dubious analogy—the argument would still be incorrect. A statute of limitations on a trust claim can begin to run before the beneficiary receives such an accounting. *See* Bogert et al., *The Law of Trusts and Trustees* § 969 (2012) (under Uniform Trust Code (UTC), action for breach of trust is barred five years after the first of several events "even if the trustee does not furnish such notice to a beneficiary"); *see also, e.g.*, Del. Code Ann. tit. 12, § 3585 (same in non-UTC jurisdiction).

Petitioner also cites (at 6) "higher-than-marketplace quality standards" requiring fiduciaries to "discharge [their] duties … solely in the interests of the participants and beneficiaries of the plan." *Metropolitan Life Ins. Co.* v. *Glenn*, 554 U.S. 105 (2008). ERISA's fiduciary obligations, however, do not govern the creation of a plan or its terms. *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 890 (1996). When those obligations do apply, the fiduciary "d[oes] its statutory ERISA duty" by acting "in conformity with the plan documents." *Kennedy*, 555 U.S. at 300; *see* 29 U.S.C. § 1104(a)(1)(D).

C. Nothing In ERISA's Text Or Regulations Prohibits Enforcement Of The Policy's Limitations Provision

Consistent with the foregoing principles, the reasonable contractual limitations provision at issue here must be enforced as written unless ERISA or its regulations specifically preclude it. They do not.

Although Congress enacted a statute of limitations to govern claims for breach of fiduciary duty, *see* 29 U.S.C. § 1113, it did not enact a statute of limitations for denial-of-benefits claims under Section 1132(a)(1)(B). As all agree, the statute is silent. Pet. Br. 9. It neither expressly prohibits a contractual limitations provision nor supplies any other limitations rule. ERISA's text requires only that a plan provide adequate notice of a denial decision and a full and fair administrative review, 29 U.S.C. § 1133, and that claimants be afforded access to federal courts to vindicate their rights, *id.* §§ 1001(b), 1132. None of these requirements addresses the limitations period applicable to such suits.

Regulations implementing ERISA likewise say nothing about the enforceability of a contractual limitations provision in a denial-of-benefits suit. *See* 29 C.F.R. § 2560.503-1. The regulations specify in great detail what an ERISA plan must do to provide a full and fair opportunity for review. Among other things, the regulations govern the amount of time a plan may take to resolve a claim initially and on appeal, *see id.* § 2560.503-1(f), (h), (i); provide for tolling of those time limits when necessary due to a "claimant's failure to submit information necessary to decide a claim," *id.* § 2560.503-1(f)(4); *see id.* § 2560.503-1(i)(4); and create exceptions to the exhaustion requirement in circum-

stances where the Department has found it necessary to adjust for any conflict between the internal review process and the availability of judicial review, *see id.* § 2560.503-1(c)(3)(i), (k)(2)(ii), (*l*). Among those exceptions, the regulations provide that if a plan misses the deadlines for resolving a claim or otherwise fails to comply with regulatory requirements, "the claimant shall be deemed to have exhausted" administrative remedies and "shall be entitled to pursue" judicial review under Section 1132(a)(1)(B). *Id.* § 2560.503-1(*l*). The regulations also provide that "any statute of limitations or other defense based on timeliness" shall be tolled during the pendency of a voluntary additional appeal where a plan offers one. *Id.* § 2560.503-1(c)(3)(ii).

The regulations thus address many details of claims processing, including the time limits and exhaustion requirements. Yet, despite the ubiquity of limitations provisions that run from the proof-of-loss deadline, the regulations are silent as to the enforceability of such a provision. Like the statute, the regulations do not supply any particular limitations provision, and they do not prohibit any contractual limitations provision.

ERISA's directive to adhere to plan terms and a century of common law recognizing the validity of reasonable contractual limitations provisions each require the Court to give effect to the Policy's reasonable limitations provision unless ERISA specifically prohibits it. Because the statute and regulations do not prohibit the provision, the limitations provision is enforceable as written and bars Ms. Heimeshoff's suit.

II. No Immutable Accrual Rule Invalidates The Policy's Limitations Provision

Lacking a textual basis for her position, Ms. Heimeshoff argues that ERISA silently incorporates a "rule" that the limitations period governing a federal statutory cause of action must run from the time a plaintiff's cause of action "accrues"—that is, when the plaintiff has a complete and present cause of action. Pet. Br. 21-29; *see also* U.S. Br. 13-16. But that "rule" merely reflects a general approach to identifying the time of accrual when a statute of limitations expressly runs from the time a cause of action "'accrues.'" *Bay Area Laundry & Dry Cleaning Pension Trust Fund* v. *Ferbar Corp. of Cal., Inc.*, 522 U.S. 192, 201 (1997). It is a default rule of statutory interpretation that recognizes that Congress usually (but not always) writes statutes that measure the limitations period from the date the cause of action "accrues" and that such language usually (but not always) refers to the date the plaintiff can file suit and obtain relief. The rule does not dictate that all statutes of limitation must be written that way, it does not apply when the limitations provision starts the period running at a time other than "accrual," and it says nothing about contracting parties' authority to agree to a limitations provision that measures the time for filing suit from a point of their choosing.

The scope of the rule is evident from the decisions of this Court Ms. Heimeshoff cites. Nearly all required the Court to interpret and apply a statutory limitations provision that ran from the date the claim "accrued." In *Gabelli*, 133 S. Ct. at 1219, for example, the statute required suit to be commenced within "'five years from the date when the claim first accrued.'" Reasoning that "accrual" normally refers to the time "'when the plaintiff has a complete and present cause of action,'" the

Court held that Congress intended the limitations period to begin at the time a fraud occurs, rather than later, upon discovery of the fraud. *Id.* at 1220. Thus, the statute of limitations ran from the time the cause of action "accrued" because Congress said so, and the Court applied the default rule to determine when that accrual occurred.

The other cases are to the same effect. In each, the Court looked to the date the cause of action arose as the trigger for starting the limitations period because the statute expressly said the period ran from the cause of action's "accrual." And in each case, the Court applied the "ordinarily applicable" rule that a statutory reference to "accrual" means the time when a plaintiff has a complete and present cause of action on which he can file suit and obtain relief. *Bay Area Laundry*, 522 U.S. at 195, 197 (applying limitations period tied to "date on which the cause of action arose" (citing *Rawlings* v. *Ray*, 312 U.S. 96, 98 (1941))); *see Wallace* v. *Kato*, 549 U.S. 384, 387 (2007) (borrowing Illinois statute running from "accru[al]" of cause of action, 735 Ill. Comp. Stat. Ann. 5/13-202 (West 2003)); *Crown Coat Front Co.* v. *United States*, 386 U.S. 503, 514 (1967) (applying statute tied to date "the right of action first accrues"); *Spannaus* v. *DOJ*, 824 F.2d 52, 55 (D.C. Cir. 1987) (applying statute requiring suit "'within six years after the right of action first accrues'").

Indeed, in *Reiter* v. *Cooper*, 507 U.S. 258, 263 (1993), the statute of limitations specified not only that the period ran "'within two years after the claim accrues,'" but also that accrual "occur[red] 'on delivery or tender of delivery by the carrier.'" The Court thus recognized that because Congress had specified the accrual date, it would be "odd" to conclude the claim had not ripened as of that date. *Id.* at 267. Similarly, in *Clark*

v. *Iowa City*, 87 U.S. (20 Wall.) 583, 589 (1875), the Court interpreted an Iowa statute requiring suit to be filed within ten years "after the[] cause[] accrue[d]," Iowa Code § 2740.4 (1872), and it cited the general accrual rule to reject the argument that the statute of limitations could "sleep[]" even *after* "a complete right of action … exists in the holder."[11]

In the decisions of this Court Ms. Heimeshoff cites that did not involve a statute of limitations running from the date of accrual, the Court simply relied on the "default rule" to interpret an ambiguous statutory limitations provision. *See Graham County Soil & Water Conservation Dist.* v. *United States ex rel. Wilson*, 545 U.S. 409, 418 (2005). Between two plausible constructions, the Court adopted the one "that start[ed] the time limit running when the cause of action … accrues." *Id.* at 419.[12]

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[11] Ms. Heimeshoff cites (at 22-23) administrative schemes in which the period for filing suit is tied to the final decision concluding a mandatory pre-suit process. *See, e.g.*, *Bowen* v. *City of N.Y.*, 476 U.S. 467 (1986). All these schemes show is that there is more than one way to draft a limitations period. As in *Bowen*, time limits are sometimes written to provide a guaranteed—usually very short—window of opportunity for a claimant to proceed from one step of review to the next. Other limitations provisions serve not to grant claimants a minimum number of days within which to sue, but to cut off liability at an ascertainable deadline by which all prelitigation steps must be completed and suit must be filed. *See, e.g.*, *McMahon* v. *United States*, 342 U.S. 25, 27 (1951); *Wolfe*, 331 U.S. at 610; *Proc*, 17 N.Y.2d at 242-245. Nothing in ERISA or the general law of limitations compels the use of one formulation over the other.

[12] Similarly, the limitations period applicable to "hybrid" suits under Section 301 of the Labor Management Relations Act—borrowed from Section 10(b) of the National Labor Relations

These decisions thus stand for the proposition that when a statute of limitations measures the time for filing suit from the date a cause of action "accrues" (or is ambiguous as to the operation of the limitations period), courts interpret the statutory language to mean that the period begins to run when the plaintiff has a complete and present cause of action. *See TRW Inc.* v. *Andrews*, 534 U.S. 19, 36-37 (2001) (Scalia, J., concurring in judgment) (federal statute "which says the [limitations] period runs from 'the date on which the cause of action arose'" should be read in light of background rule that limitations periods "begin[] to run at the time the plaintiff 'has the right to apply to the court for relief,'" not when the plaintiff later discovers the injury).[13]

Moreover, that rule of statutory interpretation is only a "default," *Graham County*, 545 U.S. at 418: Where the legislature clearly indicates that the limitations period runs from a time other than the cause of action's accrual, the standard rule does not apply. *Crown Coat Front*, 386 U.S. at 514; *see Gabelli*, 133 S. Ct. at 1224 (rule applies absent contrary "mandate from

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Act—is ambiguous as to its start date when applied in the hybrid-suit context. *See DelCostello* v. *International Bhd. of Teamsters*, 462 U.S. 151, 155 (1983); 29 U.S.C. § 160(b) (period starts when unfair labor practice "occur[s]"). As in *Graham County*, the circuit court cases Ms. Heimeshoff cites (at 25 n.7) follow the default approach to resolve that ambiguity.

[13] *See also* 1 Corman § 6.1 ("Frequently, legislation stating that commencement occurs when the plaintiff's cause of action accrues is interpreted by courts to mean that moment when the plaintiff has a complete and present cause of action."); 1 Wood, *A Treatise on the Limitation of Actions At Law and in Equity* § 117 (4th ed. 1916) ("By the express terms of all the statutes, the statute of limitations only begins to run from the time when the right of action accrues[.]").

Congress"); *Bay Area Laundry*, 522 U.S. at 201 (same); *Reiter*, 507 U.S. at 267 (same); *Graham County*, 544 U.S. at 419 n.2 ("We apply the rule that Congress generally drafts statutes of limitations to begin when the cause of action accrues to resolve [an] ambiguity, not to create it in the first instance.").

In *Dodd* v. *United States*, 545 U.S. 353 (2005), for example, this Court considered the limitations provision of the federal habeas statute, which tied the start of the limitations period not to the accrual of the cause of action, but instead to a series of other events. The "standard rule that the limitations period commences when the plaintiff has a complete and present cause of action" therefore had no bearing. *Id.* at 360 (internal quotation marks omitted). Rather, the "only natural reading" of the limitations provision was one in which the period began to run *before* some applicants could petition for relief. *Id.* at 358-359.

A different rule also applied in *McMahon* v. *United States*, 342 U.S. 25, 27 (1951), where the Court construed the limitations period in the Suits in Admiralty Act "to be computed from the date of the injury," not when the plaintiff's claim was disallowed through a mandatory administrative process. The Court acknowledged the plaintiff's contention that "the period of limitations c[ould] not start to run until his claim ha[d] been administratively disallowed because only then does his 'cause of action' arise." *Id.* at 26-27. But the Court rejected that argument based on the statute's text and history. *Id.* at 27. The purpose of the administrative process in that case was to allow an opportunity to resolve the dispute without litigation, not to give the plaintiff the "power, by delaying its filing, to

postpone indefinitely commencement of the running of the statute of limitations." *Id.*[14]

The rule upon which Ms. Heimeshoff relies is thus doubly inapplicable. First, the limitations provision here, like the one in *Dodd*, "clearly specifies the date on which the limitation period begins to run," 545 U.S. at 360, and it sets that date at a time other than the cause of action's "accrual." A default rule defining when a cause of action "accrues" therefore does not determine when the period begins to run.

Second, this case concerns a *contractual* limitations provision. As discussed, *supra* Part I.A, parties are free when entering into a voluntary agreement to adopt a limitations provision by contract, so long as the provision is reasonable and not specifically prohibited by statute. None of the cases cited by Ms. Heimeshoff or the United States involves a contractual limitations provision. They reflect only a rule developed to discern legislative intent, which does not limit the terms private contracting parties may adopt. Moreover, none of the cases hints—contrary to more than a century of case law, *see supra* Part I.A—that statutory *silence* can prohibit the enforcement of a reasonable contractual limitations provision.

[14] The Court in *McMahon* also noted that if the plaintiff's claim was not administratively disallowed within a specified time, the claim would be presumed denied, and the plaintiff would be free to sue. *See* 342 U.S. at 28. The same is true here. *See* 29 C.F.R. § 2560.503-1(*l*).

III. ERISA's Remedial Scheme Does Not Implicitly Prohibit The Limitations Provision

The absence in ERISA's text and regulations of any prohibition against the Policy's limitations provision ought to end the matter. Ms. Heimeshoff argues, however, that ERISA's remedial "scheme" and "purposes" implicitly preclude the provision's enforcement.

Notably, her argument is not that ERISA requires claimants to have more time to sue than she had here. Ms. Heimeshoff does not dispute—and the United States all but concedes (at 23 n.4)—that a one-year limitations period running from the final adverse decision would be enforceable. That hypothetical provision would have given Ms. Heimeshoff *less* time to sue than Hartford's Policy allowed in this case. Ms. Heimeshoff nonetheless contends that, by measuring the time for filing suit from a date that precedes the accrual of a cause of action, Hartford's longer limitations provision undermines ERISA's remedial regime because its enforcement *theoretically* could limit a claimant's access to judicial review or impede the administrative appeal in rare cases. This speculation is baseless and cannot justify judicial revision of the plan.

A. Perceived Inconsistency With One Of ERISA's Competing Purposes Is Insufficient To Invalidate A Plan Term

As an initial matter, "vague notions" about ERISA's "'basic purpose'" are by themselves an "inadequate" basis to override a plan's written terms. *Mertens*, 508 U.S. at 261-262. ERISA is an "enormously complex and detailed" statute "that resolved innumerable disputes between powerful competing interests—not all in favor of potential plaintiffs." *Id.* at 262. It does not have one overriding purpose. The Act's

"principal function" is not to achieve a free-floating remedial goal (at the expense of encouraging plan formation), but "to 'protect contractually defined benefits'" embodied in the written plan. *McCutchen*, 133 S. Ct. at 1548.

Given this "'careful balance[e],'" *Davila*, 542 U.S. at 215, this Court has refused to read into ERISA requirements, remedies, or prohibitions that do not appear in its text, even where doing so would purportedly advance a remedial aim. In *Guidry* v. *Sheet Metal Workers National Pension Fund*, 493 U.S. 365, 376 (1990), for example, the Court found it "[in]appropriate to approve any generalized equitable exception" to ERISA's anti-assignment provision, even to remedy "employee malfeasance or … criminal misconduct." The anti-assignment provision "reflect[ed] a considered congressional policy choice," and "[i]f exceptions to this policy [we]re to be made, it [would be] for Congress to undertake that task." *Id.*

The Court has similarly "emphasized [its] unwillingness to infer causes of action in the ERISA context, since th[e] statute's carefully crafted and detailed enforcement scheme provides 'strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.'" *Mertens*, 508 U.S. at 254 (quoting *Russell*, 473 U.S. at 146-147); *see also Pilot Life*, 481 U.S. at 54 (declining to "undermine[]" ERISA's balance of policy choices by permitting claimants to pursue remedies Congress rejected).

Similarly, even given ERISA's "expansive" preemptive scope, *Davila*, 542 U.S. at 208, the Court has held that speculative conflicts with ERISA's remedial "scheme" do not warrant preemption of state insurance laws mandating policy terms, *see, e.g.*, *Rush*

Prudential, 536 U.S. at 375-385; *UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358, 375-378 (1999). That is true even where the impact of those laws on claims procedures "could mean the difference between success and failure for a beneficiary." *Rush Prudential*, 536 U.S. at 380. Only those state insurance laws purporting to provide "additional claim[s] or remed[ies]" have been found so incompatible with ERISA's remedial scheme as to frustrate congressional intent. *Id.* And that conclusion rested on numerous clues as to Congress's preemptive intent in ERISA's text, structure, and legislative history. *Id.* at 377-381. Absent comparably clear evidence, this Court has observed that "further limits on [state] insurance regulation" based on a perceived conflict with ERISA's remedial scheme "are unlikely to deserve recognition." *Id.* at 381.[15]

Thus, a perceived conflict with ERISA's general remedial aims—even if it had any basis in fact—would be an insufficient basis to read into the statute a prohibition that does not appear there or to invalidate a plan term based on that implied prohibition. To the contrary, a plan term may be invalidated only to the degree that it specifically conflicts with an express term of the

[15] The United States is thus wrong to assume (at 28 n.5) that ERISA "likely" preempts the many state laws that require insurance policies to include a limitations provision like Hartford's. *See UNUM Life Ins.*, 526 U.S. at 374-377 (state laws mandating insurance contract terms "regulate[] insurance" and thus fall within ERISA's saving clause absent the kind of conflict discussed above); *see also Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 758 (1985).

statute or its implementing regulations. *See Black & Decker*, 538 U.S. at 829-834; *supra* Part I.B.[16]

B. Enforcing Contractual Limitations Provisions Promotes Plan Formation

Ms. Heimeshoff's purposive argument also fails because enforcing a reasonable limitations provision in an ERISA plan actually promotes many beneficial goals of the statute. As explained, *see supra* Part I.B, adherence to the "directives of the plan documents," *Kennedy*, 555 U.S. at 300, "promotes [the] predictability" that induces employers to offer plans in the first place, *Conkright*, 130 S. Ct. at 1649. That is particularly so when the term is one that allows the plan to protect itself from the surprise of untimely and stale litigation.

Including a limitations provision in the plan avoids the uncertainty and disuniformity that could result if ERISA claims were subject to the state statutes of limitations that courts might otherwise borrow. As Ms. Heimeshoff observes (at 9), state statutes of limitations for breach-of-contract actions vary widely, "rang[ing] from three to fifteen years." And claimants have flexi-

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[16] The United States submits (at 17-18) that a plan provision "purporting to exempt the plan administrator from liability for suits" under Section 1132(a)(1)(B) "would be void." That is true, of course, but the reason is not because the term would be inconsistent with ERISA's free-floating remedial spirit, but because the text of the statute specifically provides for such liability and prohibits contrary terms. *See* 29 U.S.C. §§ 1110(a), 1132(a)(1)(B). Nor does a contractual limitations period "oust the courts of jurisdiction by excluding the assured from all resort to them for his remedy." *Riddlesbarger*, 74 U.S. (7 Wall.) at 391; *cf.* U.S. Br. 18. Rather, a limitations period "simply exacts promptitude on the part of the assured in the prosecution of his legal remedies." *Riddlesbarger*, 74 U.S. (7 Wall.) at 391.

bility about where to sue and thus what limitations provision to invoke. Without a contractual limitations provision, an insurer could not easily predict what limitations period will apply, making it more difficult to estimate the timing and volume of claims. A contractual provision provides the predictability and uniformity ERISA is meant to promote. *See Conkright*, 130 S. Ct. at 1649.

In contrast, a judicial decision categorically invalidating a plan's written limitations provision based on a perceived conflict with general ERISA policy would thwart ERISA's purposes. Employers and insurers justifiably rely on plan terms, including the limitations provisions required by state law. Wholesale invalidation of that mandatory term would upend that reliance interest and create significant uncertainty about the governing limitations period: May a court "blue-pencil" an ERISA plan so that the three-year limit in the plan continues to apply, but runs from the final denial? *See Belrose* v. *Hartford Life & Accident Ins. Co.*, 478 F. App'x 21, 23-24 (4th Cir. 2012). Or is the entire provision unenforceable such that the court should borrow an analogous state statute of limitations? *See Gillespie* v. *CUNA Mut. Group Long Term Disability Ins. Policy*, 2010 WL 1050286, at *3-4 (S.D. W. Va. Mar. 18, 2010); *compare* Pet. C.A. Br. 10 (arguing that Connecticut's six-year statute of limitations must apply), *with id.* 37 (positing that "the policy's limitations period could apply" if it ran from denial of the administrative appeal). And how do insurers comply with state laws mandating use of the provision?

Invalidation of the proof-of-loss provision in favor of a rule running the limitations period from exhaustion of administrative remedies also raises the question of when exhaustion occurs. *See Wetzel* v. *Lou Ehlers Ca-*

dillac Group Long Term Disability Ins. Program, 222 F.3d 643, 649 (2000) (denial-of-benefits claim accrues either upon actual denial or when claimant has reason to know of denial); *Fenwick* v. *Merrill Lynch & Co.*, 570 F. Supp. 2d 366, 371 (D. Conn. 2008) (under discovery rule, limitations period can run before final denial when claimant knows of clear repudiation). Similarly, when would the limitations period begin to run if a claimant is excused from exhausting administrative remedies? *See, e.g.*, *Hill* v. *Blue Cross & Blue Shield of Mich.*, 409 F.3d 710, 718-719 (6th Cir. 2005) (futility exception); *Smith* v. *Blue Cross & Blue Shield United of Wis.*, 959 F.2d 655, 659 (7th Cir. 1992) (exception when claimant "lack[s] … meaningful access" to review procedures). And when does the period run if a claimant is "deemed to have exhausted" administrative remedies and entitled to pursue judicial review based on the plan's failure to follow regulatory requirements? *See* 29 C.F.R. § 2560.503-1(*l*); *see also Spannaus*, 824 F.2d at 59 (statute of limitations running from conclusion of mandatory administrative process runs from point the claim is deemed denied by operation of law, not final agency decision).

Enforcing the Policy's clear requirement that a suit challenging a denial of benefits must be brought within three years after the deadline for proof of loss avoids these questions. Far from violating ERISA's animating policy concerns, it respects the parties' expectations that the "directives of the plan documents" will be followed. *Kennedy*, 555 U.S. at 300.

C. The Limitations Provision Does Not Undermine ERISA's Remedial Scheme

Contrary to Ms. Heimeshoff's speculation, it is highly unlikely if not impossible that the Policy's limita-

tions provision would actually prejudice a diligent claimant. The provision allows more than enough time to complete a thorough administrative review and file suit if need be. Ms. Heimeshoff thus fails to cite a single example in which a diligent claimant was stymied by the limitations provision from vindicating her rights under the statute. Nor does she cite any other evidence that this ubiquitous limitations provision undercuts ERISA's remedial scheme in any way that cannot be addressed through the tools courts have always applied to statutes of limitations.

1. The limitations provision will virtually never disrupt the internal review or leave a claimant insufficient time to sue

a. Regulations strictly limit the time a plan may take to resolve a claim. In disability cases, the plan must make an initial decision within 45 days, with two 30-day extensions permitted when "necessary due to matters beyond the [plan's] control." 29 C.F.R. § 2560.503-1(f)(3). The claimant has up to 180 days to appeal, *id.* § 2560.503-1(h)(3)(i), (h)(4), and the plan must decide the appeal within 45 days, *id.* § 2560.503-1(i)(3)(i), with one 45-day extension permitted, *id.* § (i)(1)(i), (i)(3)(i). While variation occurs, the baseline schedule for exhausting internal review is thus, at most, 375 days.[17]

A plan that misses these deadlines is unlikely to succeed in blocking a claimant's access to judicial re-

[17] State laws may further restrict the time an insurer can take to decide a claim. *See, e.g.*, Cal. Ins. Code § 10111.2; *see also* 29 C.F.R. § 2560.503-1(k) (state claims-processing rules not preempted).

view even if it wanted to and can face significant penalties for trying. As noted, if the plan fails to comply with the deadlines or other regulatory requirements, "the claimant shall be deemed to have exhausted" administrative remedies and "shall be entitled to pursue any available remedies" under Section 1132(a). 29 C.F.R. § 2560.503-1(*l*). If that "deemed-denied" provision is invoked, the plan risks losing the deferential standard of review that would otherwise apply to its benefits determination. *See* 63 Fed. Reg. 48,390, 48,397 (Sept. 9, 1998) (arguing for de novo review in deemed-denied cases).[18] Moreover, a plan's consistent failure to meet the regulatory deadlines could be deemed a violation of Section 1133's "full and fair review" requirement.

The regulations create far greater opportunity for the *claimant* to delay resolution of the administrative appeal. Ms. Heimeshoff notes (at 8, 42) that if a plan requests more information, the regulatory deadlines may be tolled until the claimant responds. *See* 29 C.F.R. § 2560.503-1(f)(4), (i)(4). Such tolling is permitted, however, only where the deadline is extended "due to a claimant's failure to submit information necessary to decide a claim." *Id.* If the claimant acts promptly, this will not draw out the claims process. *See* 65 Fed. Reg. 70,246, 70,250 (Nov. 21, 2000) (tolling available "if the reason for taking the extension" is claimant's failure to provide information). The Department of Labor

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[18] *See, e.g.*, *Rasenack ex rel. Tribolet* v. *AIG Life Ins. Co.*, 585 F.3d 1311, 1315-1318 (10th Cir. 2009) (applying de novo review); *Nichols* v. *Prudential Ins. Co. of Am.*, 406 F.3d 98, 109-110 (2d Cir. 2005) (same); *but see Southern Farm Bureau Life Ins. Co.* v. *Moore*, 993 F.2d 98, 101 (5th Cir. 1993) (applying deferential review).

thus promulgated this tolling provision only after concluding that "providing a limited extension opportunity" would afford plans the "flexibility necessary to handle all claims appropriately" *without* sacrificing "prompt decisionmaking." *Id.* at 70,249, 70,250.[19]

Accordingly, even assuming the internal process takes the full amount of time permitted (or even longer if the claimant extends it), the limitations provision will virtually never leave a claimant without ample time to sue. If the deadlines are strictly observed, a claimant will have about two years in which to sue after a final appeal denial. And even in a protracted case like this one, where Hartford granted Ms. Heimeshoff's multiple requests for extensions of time to submit information in support of her claim and appeal, she still had more than a year remaining on the limitations period once the administrative process concluded. Indeed, the most extreme hypothetical Ms. Heimeshoff's amici can devise, which posits a claim and appeal taking upwards of 21 months, would still leave more than a year to sue. *See* United Policyholders Br. 4-8.

Any of these scenarios leaves claimants more than enough time to prepare and file a denial-of-benefits

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[19] Here, for example, although Ms. Heimeshoff asserts (at 42-43) that Hartford made "multiple requests at different intervals," the record shows that Hartford's requests were for one thing: a report from Ms. Heimeshoff's rheumatologist concerning her functionality and capacity to perform sedentary work. *Supra* pp. 7-8. Hartford had to ask "multiple" times only because it wanted to consider her claim on a complete record and its previous requests had gone unanswered. In a case where a plan did make multiple demands for new proof of loss, such demands potentially could be construed to establish a new proof-of-loss deadline for purposes of the limitations provision, depending on the circumstances.

suit. Such a suit is "a review proceeding, not an evidentiary proceeding." *Doe* v. *Blue Cross & Blue Shield United of Wis.*, 112 F.3d 869, 875 (7th Cir. 1997). The claimant will have already developed evidence of her disability through the claims process, and the record in court generally will be limited to that administrative record. *See, e.g.*, *Fleisher* v. *Standard Ins. Co.*, 679 F.3d 116, 121 (3d Cir. 2012); *Evans* v. *UnumProvident Corp.*, 434 F.3d 866, 876 (6th Cir. 2006). Here, for example, Ms. Heimeshoff's complaint alleged no facts outside the administrative record. JA60-83. The Section 1132(a)(1)(B) proceeding is thus "the equivalent of a suit to set aside an administrative decision," which often must be initiated within 30 or 60 days—a fraction of the time the Policy allows. *Doe*, 112 F.3d at 875.

If, in an exceptional case, a claimant runs out of time because the insurer delays the processing of the claim, fails to disclose relevant information, or misleads the claimant, a court may ameliorate any prejudice by applying estoppel or waiver. *See Thompson*, 136 U.S. at 298-299 ("If … the failure of the plaintiff to sue within the time prescribed by the policy, computing the time from the date of the fire, was due to the conduct of the company, it cannot avail itself of the limitation[.]"); *FDIC* v. *Hartford Accident & Indem.*, 97 F.3d at 1151-1152; Jerry § 85[b]; 17 *Couch* §§ 237:76, 238:3, 238:20-81 (2005). And where a diligent claimant is prevented from suing on time by circumstances beyond her control or the insurer's failure to provide adequate notice, equitable tolling may apply. *See, e.g.*, *Irwin* v. *Department of Veterans Affairs*, 498 U.S. 89, 95 (1990) ("Time requirements in lawsuits between private litigants are customarily subject to 'equitable tolling.'"); *see also Veltri* v. *Building Serv. 32B-J Pension Fund*, 393 F.3d 318, 322-323 (2d Cir. 2004); *Ortega Candelaria* v. *Or-*

thobiologics LLC, 661 F.3d 675, 679-681 (1st Cir. 2011); 16 *Couch* § 235:82-83.

b. Contractual limitations provisions requiring suit to be commenced within three years after the proof-of-loss deadline have been in widespread use throughout ERISA's lifetime. *See supra* pp. 4-6. If these provisions regularly frustrated ERISA's remedial scheme, evidence of that ought to be readily available. Yet Ms. Heimeshoff cites no evidence that these provisions actually undercut claimants' access to court or the efficacy of the internal review process.[20]

To the contrary, Ms. Heimeshoff concedes that the internal review system works: Out of hundreds of thousands of benefit claims filed annually, only a small fraction end up in court. Pet. Br. 9. In part, that statistic reflects the fact that "insurers approve the vast majority of claims they receive." ACLI, *Private Long-Term Disability Income Insurance* 2 (2010). According to one 2008 study, group disability insurers approved 78.8 percent of submitted claims. *Id.* Of claims that were not approved, 25 percent were denied because the claimant recovered before expiration of the Elimination Period. *Id.* And when claims are denied and judicial review follows, timeliness is rarely an issue.

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[20] Ms. Heimeshoff claims (at 26) the limitations provision could lead to absurd results in a benefits-termination case, but her assertion is unfounded. Termination presents a different situation, and the limitations provision does not necessarily operate the same way as in an initial claims decision. When a plan asks a claimant who has been receiving benefits to submit new proof of loss substantiating her continued disability, that request would set a new deadline for proof of loss, triggering a fresh limitations period. *See, e.g.*, *Rotondi* v. *Hartford Life & Accident Ins. Co.*, 2010 WL 3720830, at *8 (S.D.N.Y. Sept. 22, 2010).

Thus, because even a lengthy administrative review process would still leave ample time to sue, it is implausible that plans or claimants would face any incentive to sacrifice the benefits of the internal review process. Claimants have good reason to present the strongest, most well-documented claim possible to the plan, both to maximize the chance of obtaining benefits without litigation and to create a favorable record for judicial review. A claimant is not going to short-change her own claim just so she will have 20 months to sue instead of 18. And for plans, engaging in "meaningful dialogue" through the internal review process helps avoid costly litigation. To the extent a claimant's desire to get paid as soon as possible or a plan's desire for finality creates any countervailing temptation to "cut short exchanges" in the administrative appeal (U.S. Br. 22), those incentives exist independently of any limitations period. The Policy's limitations provision cannot make more than a marginal difference in this existing mix of incentives.

Finally, if this ubiquitous limitations provision actually interfered with ERISA's remedial scheme in real cases, one would have expected the Department of Labor to address the problem in its claims-processing regulation or by proposing legislation to address it. In enacting the current regulation, the Department received comments on the time taken to process claims. 65 Fed. Reg. at 70,249. And it concluded that the deadlines it adopted would ensure both "timely benefit determinations" and a reasonable opportunity for "full and fair review of denied claims." *Id.* at 70,246; *see also id.* at 70,249-70,250; 63 Fed. Reg. 48,393 & n.10, 48,394. The Department also created regulatory exceptions to the exhaustion requirement and precluded assertion of the statute of limitations in particular circumstances in

which it found that an extended internal review process could delay access to court. *See* 29 C.F.R. § 2560.503-1(c)(3)(i), (c)(3)(ii), (k)(2)(ii), (*l*). Yet the Department evidently saw no need for any action regarding the proof-of-loss limitations provision. That inaction, amid such close scrutiny of the claims process, speaks volumes.

2. Enforcing a contractual limitations provision where "reasonable" is workable, certain, and faithful to plan terms

As discussed, *supra* Part I.A, this Court has long directed that contractual limitations provisions should be enforced so long as the period is not "unreasonably short." *Harriman Bros.*, 227 U.S. at 672. Ms. Heimeshoff predicts (at 43-48) that this familiar principle—and the prospect of tolling in exceptional cases—will result in a flood of "satellite litigation" and uncertainty as courts decide, willy-nilly, whether to enforce the terms of the plan. That caricature provides no basis to invalidate the limitations provision.

Courts have applied the reasonableness standard to contractual limitations provisions without difficulty for over a century. *See, e.g.*, *Riddlesbarger*, 74 U.S. (7 Wall.) at 390; *supra* Part I.A. Reasonableness is ordinarily a straightforward question that can be addressed with an economy of analysis by looking at the provision on its face. *See, e.g.*, *Leigh Ellis*, 260 U.S. at 689 ("The time allowed was reasonable."); *Leatherwood*, 250 U.S. at 481 ("The provision … not being unreasonable, was valid[.]" (citation omitted)); *Harriman Bros.*, 227 U.S. at 673 ("The provision requiring suit to be brought within [90] days is not unreasonable."). The three-year provision here is facially reasonable. And claimants whose cases go to court rarely have trouble filing suit

within that period. The flood of litigation Ms. Heimeshoff warns of is thus, at most, a trickle.

Where any deeper case-specific treatment is appropriate, the lower courts have had no difficulty developing tests to assess the reasonableness of limitations periods in commercial contracts, ERISA plans, and insurance policies. *Compare*, *e.g.*, *Doe*, 112 F.3d at 875 (ERISA plan provision reasonable), *and Davidson* v. *Wal-Mart Assocs. Health & Welfare Plan*, 305 F. Supp. 2d 1059, 1070, 1075 (S.D. Iowa 2004) (same), *with Henning Nelson Constr. Co.* v. *Fireman's Fund Am. Life Ins. Co.*, 383 N.W.2d 645, 651 (Minn. 1986) (insurance policy provision unenforceable where insurer did not deny claim until after expiration), *and Brown & Guenther* v. *North Queensview Homes, Inc.*, 18 A.D.2d 327, 329-331 (N.Y. App. Div. 1963) (limitations provision in commercial contract unreasonable "in the light of the facts presented").[21]

Ms. Heimeshoff objects (at 44-45) that an employee cannot examine Hartford's Policy and know *ex ante* what limitations provision would be enforced in a given case. But the Policy states unambiguously that suit must be brought within three years after proof of loss is due. A claimant seeking to "evaluate her potential rights" (Pet. Br. 45) should conclude that suit must be filed before that time expires. The fact that enforcement of the limitations period might be tolled or waived or precluded based on the facts of a particular case does not offend ERISA or cloud the plan's meaning. ERISA requires a written plan that informs employees of their "rights and obligations," *Curtiss-Wright*, 514 U.S. at 83;

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[21] *See also, e.g.*, *Thurman* v. *DaimlerChrysler, Inc.*, 397 F.3d 352, 357-359 (6th Cir. 2004).

it does not require the clairvoyance to know how those rights and obligations will apply in all circumstances. A plan term providing that benefits are payable upon "total disability" is not invalid merely because it sets a standard that must be applied to facts. *Cf. Metropolitan Life Ins. Co.* v. *Glenn*, 554 U.S. 105, 117 (2008) (courts "review[ing] the lawfulness of benefit denials" often "tak[e] account of several different, often case-specific, factors").

Moreover, the "uncertainty" Ms. Heimeshoff perceives in the requirement that contractual limitations provisions be "reasonable" characterizes *all* statutes of limitations. Ms. Heimeshoff concedes (at 32-33) that state equitable tolling rules would apply in an ERISA case governed by a state statute of limitations. In such a case, "[n]o one could be sure" *ex ante* whether the statute of limitations would be enforced or tolled. Pet. Br. 45. If ERISA did not tolerate that "uncertainty," no limitations period could ever apply.

In any event, as discussed, Ms. Heimeshoff's position entails numerous uncertainties of its own, most of which are far more difficult to resolve. *Supra* pp. 38-39. Nor is her position unburdened by line-drawing (*cf.* Pet. Br. 45): Would a provision requiring suit to be filed within *ten* years after proof of loss is due be enforceable? It would be absurd to say no. Yet, if such a provision is enforceable, then the question presented here comes down to whether the length of the limitations period allows a reasonable time to complete a meaningful administrative review and file suit—an inquiry that confirms the validity of the provision at issue.

Nor does *enforcing* the contractual limitations provision as written, subject to reasonableness and tradi-

tional equitable principles, violate ERISA's mandate to adhere to the written plan. *Cf.* Pet. Br. 43-48. As this Court explained in *McCutchen*, courts applying an ERISA plan "properly take[] account of background legal rules … that typically or traditionally have governed a given situation when no agreement states otherwise." 133 S. Ct. at 1549. Where a plan does not address an issue, such background rules give "the best indication of the parties' intent." *Id.* at 1550.

Equitable tolling and waiver or estoppel in cases of misconduct or unreasonableness are precisely the types of background rules that, "in the absence of a contrary agreement," *McCutchen*, 133 S. Ct. at 1550, parties will expect courts to apply. *See, e.g.*, *Irwin*, 498 U.S. at 95 ("Time requirements in lawsuits between private litigants are customarily subject to 'equitable tolling.'"); *Cange*, 826 F.2d at 585 (doctrine of estoppel is "'deeply rooted in and integral to our jurisprudence'"). The Policy says nothing to oust these doctrines. When a plan "leaves space" for background equitable rules to apply, it does not offend the parties' reasonable expectations or the written-plan requirement to apply them. *McCutchen*, 133 S. Ct. at 1549. It is Ms. Heimeshoff's call for wholesale revision or invalidation of the limitations provision that would do maximal violence to the written plan.

3. "Automatic" tolling is unavailable

For the first time in this Court, Ms. Heimeshoff argues (at 33-39) that if the Policy's limitations provision applies, state law tolls the period automatically pending exhaustion of administrative remedies. This argument is waived. Below, Ms. Heimeshoff sought case-specific "equitable tolling" based on Hartford's alleged failure to provide adequate notice of the limitations period.

Pet. C.A. Br. 50. That is the argument the lower courts considered and rejected, Pet. App. 4, 15-18, and as to which this Court denied review, *see* Pet. i, 2-3, 11, 31-37. Ms. Heimeshoff's new argument is fundamentally different: She calls for automatic tolling in all cases, without regard to the claimant's diligence or other case-specific circumstances. Pet. Br. 33-39. She did not present this argument below, nor did the parties brief the many subsidiary questions it raises. The Court should not consider it. *E.g.*, *Sprietsma* v. *Mercury Marine*, 537 U.S. 51, 56 n.4 (2002).

In any event, *McCutchen* forecloses the argument. Even if automatic tolling of the type Ms. Heimeshoff seeks were a settled feature of applicable law—and it is not—applying it to override plan terms would violate ERISA. The Policy specifies the length of the limitations period and the time the period begins to run. An automatic tolling rule would effectively nullify those terms. Where "[t]he express contract term … contradicts" the purported background rule, "the agreement must govern." *McCutchen*, 133 S. Ct. at 1549; *see also Amara*, 131 S. Ct. at 1877 (court cannot alter plan terms "where that change, akin to reforming a contract, seems less like the simple enforcement of a contract as written and more like an equitable remedy").

Ms. Heimeshoff is also wrong about the purported background rule. This Court's tolling principles require the party seeking relief to demonstrate that he exercised reasonable diligence and that "'some extraordinary circumstance stood in his way.'" *Holland* v. *Florida*, 130 S. Ct. 2549, 2562 (2010); *see also Rotella* v. *Wood*, 528 U.S. 549, 560-561 (2000) (tolling is "the exception, not the rule"); *Irwin*, 498 U.S. at 96 (tolling applies "sparingly" and not when a "claimant failed to exercise due diligence"). Thus, in *Wallace*, 549 U.S. at

396, the Court rejected an "omnibus tolling" approach under which the statute of limitations on a false imprisonment claim would be tolled automatically while suit was barred by *Heck* v. *Humphrey*. The Court explained: "[e]quitable tolling is a rare remedy to be applied in unusual circumstances, not a cure-all for an entirely common state of affairs." *Id.* Similarly, in *Pace* v. *DiGuglielmo*, 544 U.S. 408, 418 (2005), the Court held that even where an exhaustion requirement prevented the petitioner from filing suit, the petitioner was "not … entitled to relief because he ha[d] not established the requisite diligence." *See also Baldwin Cnty. Welcome Ctr.* v. *Brown*, 466 U.S. 147, 151 (1984) ("One who fails to act diligently cannot invoke equitable principles to excuse that lack of diligence.").[22]

Other federal courts have followed suit, holding that tolling applies during the pendency of administrative proceedings "'only when [a] plaintiff is *prevented from filing* despite exercising that level of diligence which could reasonably be expected in the circumstances.'" *Gonzalez* v. *Hasty*, 651 F.3d 318, 322 (2d Cir. 2011); *see, e.g.*, *Smith* v. *McGinnis*, 208 F.3d 13, 17-18 (2d Cir. 2000); *Heck* v. *Humphrey*, 997 F.2d 355, 357 (7th Cir. 1993), *aff'd*, 512 U.S. 477 (1994).[23] A tolling principle that takes no account of diligence is thus far from the "strong and uniform" background rule that

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[22] Ms. Heimeshoff cites (at 35-36) *Johnson* v. *Railway Express Agency, Inc.*, 421 U.S. 454, 463 (1975), but that decision *rejected* the application of tolling.

[23] Every decision Ms. Heimeshoff cites (at 37 n.9) tolling the limitations period under the Prison Litigation Reform Act either applied state law (or cited precedent applying state law), refused to apply automatic tolling, or applied tolling only where the plaintiff acted diligently.

the drafters of an ERISA plan would expect to apply. *McCutchen*, 133 S. Ct. at 1549.

Nor would state law support Ms. Heimeshoff's position, even if it applied.[24] Connecticut law holds that "'[c]ontracting parties are free to adopt an unambiguous contract provision' limiting the time in which an insurance claim must be filed," and "when they do so, 'failure to comply with the terms therein bar[s] recovery.'" *Voris* v. *Middlesex Mut. Assurance Co.*, 999 A.2d 741, 748 (Conn. 2010); *see also Chambers*, 1883 WL 1583, at *1-2 (applying insurance policy limitations provision without tolling during 60-day waiting period); *Chichester*, 51 A. at 547 (determining whether waiver or estoppel apply by reference to facts of particular case).[25]

Practice in other States is both irrelevant and varied. *Supra* n.24. In the insurance context, although a minority of state courts toll the limitations period during a 60-day waiting period, "[t]he majority of courts have refused to toll a limitations provision during the initial non-suit period or during the insurer's investiga-

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[24] State law does not govern the availability of tolling here. When federal courts borrow a state statute of limitations, they also borrow the tolling principles of the same State. *Hardin* v. *Straub*, 490 U.S. 536, 539 (1989); *Board of Regents of Univ. of State of N.Y.* v. *Tomanio*, 446 U.S. 478, 483-484 (1980). But if the Policy's limitations provision is enforceable (a question of federal law), no borrowing occurs.

[25] In *Perzanowski* v. *City of New Britain*, 440 A.2d 763, 765 (Conn. 1981), the court *declined* to toll a statute of limitations pending an earlier action and recognized only that tolling *might* apply in cases where "the pendency of the prior action … prevent[s] enforcement of the remedy sought in the later action." *See also Gager* v. *Sanger*, 897 A.2d 704, 709 (Conn. App. Ct. 2006).

tion." *FDIC* v. *Hartford Accident & Indem.*, 97 F.3d at 1150 (collecting cases). Many of the cases Ms. Heimeshoff cites apply tolling only as a case-specific principle requiring a showing of diligence. *E.g.*, *Braxton* v. *Zavaras*, 614 F.3d 1156, 1160 (10th Cir. 2010). Of the minority of States Ms. Heimeshoff cites that recognize a version of automatic tolling, most do so only by statute. State practice thus provides scant support for Ms. Heimeshoff's assertion of a general, common-law principle of automatic tolling that applies even where a plaintiff has slept on her rights.

* * *

Applying automatic tolling as Ms. Heimeshoff suggests—without regard to a claimant's diligence, and motivated only by bare conjecture that ERISA's remedial scheme *might* be frustrated in a theoretical case—would effectively nullify the Policy's express limitations provision, no differently than if the Court held the provision categorically unenforceable. Either course would contravene a century of precedent upholding the right of contracting parties to adopt a reasonable limitations provision and would impermissibly rewrite the terms of the plan. Whether a categorical rule prohibiting enforcement of a proof-of-loss limitations provision would improve or disrupt the resolution of ERISA claims is a policy judgment that should be informed by empirical investigation and consider the competing interests of claimants and plans, including insurers' obligation under state law to include the provision in their policies. Crafting such a rule in this case would exceed "the scope of permissible judicial innovation." *Black & Decker*, 538 U.S. at 831.

CONCLUSION

The court of appeals' judgment should be affirmed.

Respectfully submitted.

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APPENDICES

29 U.S.C. §1102. Establishment of plan

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

* * *

29 U.S.C. §1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

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

(ii) defraying reasonable expenses of administering the plan;

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

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless un-

der the circumstances it is clearly prudent not to do so; and

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

* * *

29 U.S.C. § 1113. Limitation of actions

No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of—

(1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or

(2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation;

except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.

29 U.S.C. § 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

* * *

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

* * *

29 U.S.C. § 1133. Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 C.F.R. § 2560.503-1. Claims procedure.

* * *

(c) *Group health plans.* The claims procedures of a group health plan will be deemed to be reasonable only if, in addition to complying with the requirements of paragraph (b) of this section—

* * *

(3) To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those permitted by paragraph (c)(2) of this section, the claims procedures provide that:

(i) The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

(ii) The plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

* * *

(d) *Plans providing disability benefits.* The claims procedures of a plan that provides disability benefits will be deemed to be reasonable only if the claims procedures comply, with respect to claims for disability benefits, with the requirements of paragraphs (b), (c)(2), (c)(3), and (c)(4) of this section.

* * *

(f) *Timing of notification of benefit determination—*

* * *

(3) *Disability claims.* In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the

claimant shall be afforded at least 45 days within which to provide the specified information.

(4) *Calculating time periods.* For purposes of paragraph (f) of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (f)(2)(iii) or (f)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

* * *

(h) *Appeal of adverse benefit determinations*—(1) *In general.* Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

* * *

(3) *Group health plans.* The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with

the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

* * *

(4) *Plans providing disability benefits.* The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

(i) *Timing of notification of benefit determination on review*—(1) *In general.* (i) Except as provided in paragraphs (i)(1)(ii), (i)(2), and (i)(3) of this section, the plan administrator shall notify a claimant in accordance with paragraph (j) of this section of the plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special

circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

* * *

(3) *Disability claims.* (i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1) of this section, except that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.

* * *

(4) *Calculating time periods.* For purposes of paragraph (i) of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (i)(1), (i)(2)(iii)(B), or (i)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

* * *

(*l*) Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the re-

quirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

* * *

THE
HARTFORD

August 4, 2006

Steven Krafchick
2701 First Ave.
#340
Seattle, WA 98121
Attn: Julia Busko

Policy Holder: Wal-Mart Stores, Inc.
Associate: Julie E. Heimeshoff
Policy Number: GLT024554

Dear Ms. Busko:

This letter is about your client's claim for Long Term Disability (LTD) benefits. I am in receipt of your 08/02/06 letter. To answer your question, if indeed you plan get the information from Dr. Saitta regarding Ms. Heimeshoff's functionality, then you do not need to appeal and you can disregard 06/12/06 letter. If, however, you do not plan to get the information we had requested from Dr. Saitta on Julie's functionality, then you do need to proceed with the appeal.

If you have any questions, please feel free to contact our office at (800) 492-5678, x64230. Our office hours are 8:00 AM to 8:00 PM EST, Monday through Friday.

Sincerely,

John Wentworth, Senior Examiner
Hartford Life and Accident Insurance Co.

Benefit Management Services
Atlanta Disability Claim Office
P.O. Box 1810

Alpharetta, GA 30023-1810
Facsimile (860) 392-0713

Krafchick Law Firm
Legal Services for Injured People

Steven P. Krafchick
Attorney at Law

Kristian E. Soholm
Attorney at Law

Legal Assistants
Julia Busko
Curtis Williams
Sarah Thai
Nadia Sayah-Sina

August 14, 2006

Via Facsimile Only: 860-392-0713

John Wentworth
Hartford Life Insurance Company
Benefits Management Services
PO Box 2999
Hartford, CT 06104

Re:	Our Client:	Julie Heimeshoff
	Your Insured:	Julie E. Heimeshoff
	Claim No.:	GLT024554
	Date of Loss:	12/8/2005

Dear Mr. Wentworth:

Thank you for your letter dated August 4, 2006. We are working on providing to you the "written proof of loss" you are requesting in order to reopen Ms. Heimeshoff's claim for long term disability benefits. We do intend to obtain information from Dr. Saitta, so, as we understand, we are not appealing, but we are working within the original claim determination.

Due to summer vacations and doctor schedules, we will not have that information for you by August 18, 2006. To permit full and fair review we require additional time to support Ms. Heimeshoff s claim. We ask that you give us at least an addition 45 days, to October 2, 2006 to submit material for your consideration. We

agree that the time for you to complete review will toll until we submit our additional material.

If we do not hear from you on or by August 17, 2006, we will assume you agree to give us the extra time. Thank you.

Very truly yours,

KRAFCHICK LAW FIRM

/s/ Steven P. Krafchick

Steven P. Krafchick

cc: Client

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