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 PETITIONER

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QUESTION PRESENTED

Whether a beneficiary's claim for wrongful denial of benefits under § 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132(a)(1)(B), accrues for limitations purposes before the beneficiary has exhausted the mandatory, pre-suit, internal review process, thereby permitting a plan to start the clock ticking on a beneficiary's civil claim before the plan has denied the application for benefits and before the beneficiary can file in court.

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INTRODUCTION

The federal courts of appeals have uniformly held that a beneficiary who seeks benefits through her employer-established ERISA plan must exhaust her plan's internal benefits resolution process before filing a federal lawsuit under ERISA's civil enforcement provisions. This mandatory pre-suit exhaustion requirement serves several important purposes: It encourages the private and nonadversarial resolution of the millions of benefits claims filed annually under ERISA, substantially reducing the burden on federal courts; promotes the consistent treatment of claims for benefits by a plan; and creates a clear record for review if resort to federal court ultimately occurs.

Consistent with the exhaustion requirement and long-standing accrual rules established by this Court, the lower courts have also held that a civil claim under § 502(a)(1)(B) alleging the wrongful denial of benefits cannot be filed—indeed, does not come into existence—until the benefits sought have actually finally been denied. In this regard, ERISA is no different from many other federal statutory regimes that couple a mandatory pre-suit process with a right to challenge the outcome of that process in court. In myriad contexts, it is the settled rule that a federal claim does not accrue for limitations purposes until that claim can be filed in court, or, in other words, until the mandatory pre-suit process has been exhausted.

The Second Circuit rejected this core feature of the law when it held that ERISA plans can start the limitations clock running on a beneficiary's federal claim challenging a wrongful denial of benefits under

§ 502(a)(1)(B) *before* the mandatory internal benefits resolution process is exhausted and the request for benefits has been denied—that is, before the beneficiary ever suffers a legal wrong.

In this case, Petitioner Julie Heimeshoff, a permanently disabled former employee of Wal-Mart Stores, Inc., sought to challenge her ERISA Plan's denial of her claim for long-term disability benefits in court. But her plan, provided by Wal-Mart and issued and administered by Hartford Life & Accident Insurance Company (collectively, Respondents) contained a set of provisions that did three things. First, it specified a three-year statute of limitations for any claim brought by a beneficiary against the Plan. Second, it started the clock ticking on this limitations period near the *start* of the mandatory internal claims process—when proof of loss was required to be furnished to the Plan. Third, it kept the clock ticking while the mandatory internal resolution process was ongoing. Under the plan, therefore, Ms. Heimeshoff's limitations clock began running years before her federal claim existed.

This approach is not only incompatible with the text, structure, and purposes of ERISA, but it violates long-settled accrual rules established by this Court. A limitations period on a federal statutory claim cannot start running before the wrongful act giving rise to the injury has ever occurred. Under Respondents' approach, the limitations clock not only starts ticking before injury, but it can completely run out.

Moreover, it is unclear why anyone would want the rule Respondents have advanced. Starting the clock ticking on a § 502(a)(1)(B) denial-of-benefits

claim before the mandatory internal resolution process is completed and keeping it running even while that process is ongoing creates perverse incentives across the board. It discourages good-faith pursuit and administration of the internal resolution process; encourages premature resort to federal court; and both creates and dramatically enhances the possibility that beneficiaries wrongfully deprived of their benefits will never have a chance to file a claim in court—even though ERISA explicitly guarantees beneficiaries "ready access to the Federal court." 29 U.S.C. § 1001(b).

Respondents recognize that their approach could yield a result that even they cannot defend: the complete elimination of a beneficiary's statutory right to seek judicial review of an ERISA benefits determination. To avoid this possibility, they urge this Court to adopt an extra-contractual, implied "reasonableness" requirement that would give ERISA beneficiaries the right to challenge a plan's accrual provision on a case-by-case basis. This approach is as awkward and inefficient as it sounds. In some cases, as Respondents acknowledge, a court would have to invalidate the provision; in others, the provision would be enforceable. No one—neither plans nor beneficiaries—would have any idea at the outset of a case whether a given accrual provision would stand or fall. Thus Respondents' approach deals a wild card into a regime that is designed to provide a uniform and predictable path to the fair resolution of benefit claims. Congress cannot have intended such a result.

OPINIONS BELOW

The summary order of the court of appeals (Pet. App. 1) is reported at 496 Fed. Appx. 129. The opinion of the district court (Pet. App. 5) is available at 2012 WL 171325.

JURISDICTION

The court of appeals' judgment was entered on September 13, 2012. The petition for a writ of certiorari was filed on December 11, 2012, and granted on April 15, 2013. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

Section 502(a)(1)(B) of ERISA, codified at 29 U.S.C. § 1132(a)(1)(B), provides:

> 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[.][1]

STATEMENT

A. Federal Statutory and Regulatory Background

This case involves employer-sponsored long term disability (LTD) insurance governed by ERISA. LTD insurance "provides income to workers whose earnings are interrupted by lengthy periods of disability." Diane B. Hill, *Employer-Sponsored Long-*

[1] This brief will refer to 29 U.S.C. § 1132 as § 502 of ERISA.

Term Disability Insurance, 110 Monthly Lab. Rev. 16 (July 1987), *available at* http://www.bls.gov/opub/mlr/1987/07/art2full.pdf. Because LTD benefits, if granted, are usually payable until retirement age, employer-sponsored benefit plans play a crucial role for employees by providing "a bridge between short-term disability benefits and retirement income." *Id.* ERISA-governed employer-sponsored LTD insurance constitutes the primary source of this type of private insurance in the United States. *See* Paul Fronstin, Employee Benefit Research Institute, No. 347, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2010 Current Population Survey* 1 (2010) *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-2010_No347_Uninsured1.pdf.

ERISA-governed LTD plans provide income protection to more than 46 million Americans, approximately one-third of the country's workforce. *See* Am. Council of Life Insurers, Private Long-Term Disability Income Insurance 1 (2010) *available at* http://www.acli.com/Consumers/Disability%20Income%20Insurance/Documents/PrivateLTDI.pdf; Bureau of Labor Statistics, Insurance Benefits (2012) *available at* http://www.bls.gov/ncs/ebs/benefits/2012/ownership/private/table12a.pdf. This case, therefore, has implications for an enormous number of workers across the country.

1. ERISA's Dual Goals

Two Congressional goals lie at the heart of ERISA: "promot[ing] the interests of employees and their beneficiaries in employee benefit plans" and "protect[ing] contractually defined benefits" to which those employees and beneficiaries are entitled. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101,

113 (1989) (citations omitted). As this Court has explained, Congress sought to avoid a regulatory regime "so complex that administrative costs, or litigation expenses" would dissuade an employer from electing to offer benefits in the first place, while at the same time establishing sufficient procedural safeguards and enforcement mechanisms that would secure employees' contractually promised benefits. *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

The result was a "comprehensive," "reticulated," and carefully "crafted" statute that strikes a balance between these competing interests. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146-47 (1985). "Nothing in ERISA requires employers to establish employee benefit plans," just as nothing in the statute mandates "what kind of benefits employers must provide if they choose to have such a plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). But once an employer elects to provide benefits (in whatever form), ERISA imposes a series of "higher-than-marketplace" procedural safeguards, coupled with a set of enforcement mechanisms, designed to protect an employee's interest in those benefits. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008); *see also Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 830 (2003).

2. ERISA's Remedial Regime

Nowhere is Congress' careful balancing more evident than in ERISA's remedial framework, which combines a mandatory internal claims process with judicial review of individual claim denials under § 502(a)(1)(B). *Glenn*, 554 U.S. at 115 (observing that ERISA "supplements marketplace and regulatory controls with judicial review"). This framework

stands as "one of the essential tools for accomplishing the stated purposes of ERISA," *Pilot Life*, 481 U.S. at 52, by "ensuring fair and prompt enforcement of rights under a plan," while avoiding regulatory complexity that might discourage employers from offering benefits. *Conkright v. Frommert*, 559 U.S. 506, 130 S. Ct. 1640, 1649 (2010).

a. As virtually every circuit has held, the benefit claim process begins with the mandatory requirement that every claimant pursue, and then exhaust, a benefits claim through a plan's own internal procedures before filing suit under § 502(a)(1)(B). *See LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248, 258 (2008) (Roberts, C.J., concurring) (discussing the "requirement, recognized by almost all the Courts of Appeals, *see Fallick v. Nationwide Mut. Ins. Co.*, 162 F. 3d 410, 418, n.4 (CA6 Cir. 1998) (citing cases), that a participant exhaust the administrative remedies mandated by ERISA § 503, 29 U.S.C. § 1133, before filing suit under § 502(a)(1)(B)").

Under § 503, an ERISA plan must establish an internal claims procedure that includes an opportunity for a participant to file an initial claim for benefits with her plan. *See* 29 U.S.C. § 1133(1). If the plan denies the claim, it must provide the participant with adequate notice of the decision and the reasons for the denial. *See id.* Then, the plan must provide at least one opportunity for an internal appeal of the initial adverse decision. *See id.* § 1133(2).

These procedural requirements are fleshed out by federal regulations that establish, among other things, time limitations for both the initial "adverse

benefit determination" and any appeal therefrom. 29 C.F.R. § 2560.503-1(f)(3). In particular, a plan has up to 105 days to initially decide a claimant's benefits claim. *Id.* (45 days with two 30-day extensions possible); *see also* 65 Fed. Reg. 70246, 70249 (2000).

Then, a claimant must be given *at least* 180 days following notification of an adverse benefit determination within which to appeal the adverse determination. *See* 29 C.F.R. § 2560.503-1(h)(3)(i), (h)(4). Once an appeal has been filed, an LTD plan has up to 90 days to resolve the appeal. *Id.* § 2560.503-1(i)(1)(i), (i)(3) (45 days with one 45-day extension possible). Importantly, however, these time limitations are not unyielding.

During both the initial determination phase and the appeal, the time limitations may be tolled indefinitely when a plan determines it needs more information from the claimant. Once a plan notifies the claimant that it needs more information, the clock stops running until the claimant responds to the request for additional information. *See id.* § 2560.503-1(f)(4), (i)(4). Under this framework, the internal claims process is open-ended. It could take less than one year, but could also last years if the periods are tolled.

This mandatory internal process was designed to serve several key purposes: to "reduce the number of frivolous law-suits under ERISA; to promote the consistent treatment of claims for benefits; to provide a nonadversarial method of claims settlement; and to minimize the cost of claims settlement for all concerned." *Schorsch v. Reliance Standard Life Ins. Co.*, 693 F.3d 734, 739 (7th Cir. 2012) (internal citations omitted). *See also Harrow v. Prudential Ins. Co. of Am.*, 279 F.3d 244, 249 (3d Cir. 2002); *Kennedy*

v. Empire Blue Cross & Blue Shield, 989 F.2d 588, 594 (2d Cir. 1993); *Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir. 1980).

Fortunately for the overburdened federal courts, the data bear out these goals. Hundreds of thousands of benefit claims are filed annually. *See, e.g.*, Council for Disability Awareness, 2012 Long Term Disability Claims Review 2 (2012) *available at* http://www.benefitdesignltd.com/pdfs/Resources/CDA_LTD_Claims_Survey_2012.pdf (estimating the number of LTD claims alone at well over 600,000). Yet only a small fraction of these claims end up in federal court. *See* U.S. Courts, Judicial Facts and Figures 3 (2011) *available at* http://www.uscourts.gov/uscourts/Statistics/JudicialFactsAndFigures/2011/Table404.pdf (reporting that 8,860 ERISA cases were filed in 2011).

b. Consistent with the above, it is only after a beneficiary exhausts her plan's internal benefits resolution procedures that ERISA provides a statutory right to file a denial-of-benefits claim in federal court under § 502(a)(1)(B). This claim is a beneficiary's "exclusive vehicle" for challenging a plan's "improper processing of a claim for benefits." *Pilot Life*, 481 U.S. at 52. And it "lies at the heart of [ERISA]," *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 65 (1987), because it "protect[s] contractually defined benefits." *Firestone Tire*, 489 U.S. at 113.

ERISA itself does not provide a statute of limitations for denial-of-benefits claims. When faced with such claims, federal courts typically apply state breach-of-contract limitations periods, which range from three to fifteen years. *See, e.g.*, *Wetzel v. Lou Ehlers Cadillac Grp. Long Term Disability Ins. Program*, 222 F.3d 643, 648 (9th Cir. 2000) (citing

cases); *Wise v. Verizon Commc'ns, Inc.*, 600 F.3d 1180, 1187 (9th Cir. 2010); *Meade v. Pension Appeals & Review Comm.*, 966 F.2d 190, 194-95 (6th Cir. 1992). For the majority of denial-of-benefit claims, these state limitations periods begin to run from the date a beneficiary's claim is finally denied by the plan under its mandatory internal review procedure—in other words, from the date a beneficiary could bring her claim challenging a plan's denial of her benefits in court. *See Held v. Mfrs. Hanover Leasing Corp.*, 912 F.2d 1197, 1205 (10th Cir. 1990) ("Uniformly, courts recognize that an ERISA cause of action accrues when an application for benefits is denied.").

B. The Hartford Plan, Which Closely Tracks Connecticut Law

1. This case involves several provisions in an ERISA welfare plan that purport to govern the time limits for challenging the denial of a claim for disability benefits. The plan at issue was issued and administered by Respondent Hartford, a Connecticut-based entity that offers insurance under ERISA as well as a wide array of other circumstances. *See* The Hartford, Insurance Plans for Individuals & Families, http://www.thehartford.com/insurance-individuals/ (last visited June 19, 2013).

In relevant part, the Hartford ERISA plan contains two provisions that provide:

> Written proof of loss must be sent to The Hartford within 90 days after the start of the period for which The Hartford owes payment.
>
> * * *

> 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 three years after the time written proof of loss is required to be furnished according to the terms of the policy.

Br. in Opp'n (BIO) App. 5a, 7a.

Together, these two provisions establish a limitations period—three years—that begins to run from a specific point: the time written proof of loss is required to be furnished under the plan. Here, that date is, in effect, 90 days from when a beneficiary becomes eligible for long-term disability benefits. *Id.* at 5a.

2. As it turns out, Connecticut state insurance law requires individual health insurance policies (though not group policies, like the plan in this case) to include a very similar set of provisions. First, Conn. Gen. Stat. § 38a-483(a)(7) requires individual health insurance policies to include the following proof-of-loss language:

> PROOFS OF LOSS: Written proof of loss shall be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other

> loss within ninety days after the date of such loss.

Conn. Gen. Stat. § 38a-483(a)(7). Second, Conn. Gen. Stat. § 38a-483(a)(11) requires that every individual health insurance policy set forth the following limitations period:

> No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Conn. Gen. Stat. § 38a-483(a)(11).[2]

3. Hartford's plan incorporates much of the language in these two provisions. But the provisions operate very differently in the two contexts. Because Connecticut insurance law (like that of many states), does not require an insurance policyholder to exhaust an internal claims process before proceeding to court, an accrual provision that starts the clock running when proof of loss is due does not interfere with a policyholder's ability to seek legal relief for her claims in a timely fashion. Instead, a policyholder may file a legal action as soon as the short, definite 60-day waiting period has elapsed, even if the insurance company has yet to act. *See,*

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[2] Forty-two other states mandate the inclusion of similar provisions in insurance policies. *See Wetzel*, 222 F.3d at 647 & 647 n.5.

e.g., *Peloso v. Hartford Fire Ins. Co.*, 267 A.2d 498, 501 (N.J. 1970).[3]

ERISA beneficiaries, in contrast, must exhaust a lengthy internal process before they may file a civil claim in court. This means that a virtually identical accrual provision, when applied to an ERISA beneficiary, creates a perverse set of incentives that—as described below—are contrary to the interests of all ERISA stakeholders.

Even though state insurance law does not require ERISA's form of mandatory exhaustion before a legal claim can be filed, there are state-law settings that do. It is telling that, in such settings, states (including Connecticut) toll the running of any limitations period until the pre-suit process is exhausted. *See Coelho v. ITT Hartford*, 752 A.2d 1063, 1068 (Conn. 1999); *N.H. Div. of Human Servs. v. Allard*, 644 A.2d 70, 72 (N.H. 1994) (listing cases applying this "general rule").

C. This Litigation

1. Background

Julie Heimeshoff worked for Wal-Mart Stores, Inc., for nearly twenty years, rising to the position of Senior Public Relations Manager. Pet. App. 6. Although she began experiencing the chronic pain and fatigue associated with fibromyalgia in the 1990s, Ms. Heimeshoff continued to work for many years. JA 53. Over time, however, her fibromyalgia, lupus, and other conditions worsened, and, by June

[3] Respondents concede that Connecticut's statutory insurance provisions, which only govern individual insurance policies, do not apply to their group insurance plan. BIO at 22 n.11. They nonetheless chose to import these Connecticut provisions into their ERISA plan, albeit in slightly modified form.

2005, the pain and fatigue had become so debilitating that Ms. Heimeshoff was forced to leave Wal-Mart. Pet. App. 6.

As part of her benefits package, Ms. Heimeshoff was eligible for Wal-Mart's group LTD plan, which is administered by Hartford. Pet. App. 6. Accordingly, on August 22, 2005, after Ms. Heimeshoff was no longer able to work, she timely applied for LTD benefits. Pet. App. 7. She supported her application with her doctor's diagnoses of lupus and fibromyalgia. *Id.* She was not represented by a lawyer.

The Plan did not respond with either an approval or a denial. Rather, three months later, on November 21, 2005, the Plan informed Ms. Heimeshoff that it needed more information from Ms. Heimeshoff's doctor regarding her functionality and that, if she did not respond within 21 days, she risked a denial. JA 6, 8. The letter claimed to be the "last request" for the information from the Plan. *Id.* at 6. On November 29, 2005, the Plan sent her another letter, again requesting the functionality information and saying that once it had the information, it expected to make a decision within 30 days. *Id.* at 9.

However, on December 8, 2005, before the original 21-day period for providing additional information expired, and one week after sending the second letter, the Plan denied Ms. Heimeshoff's claim. *Id.* at 11-15. The Plan explained that it was denying the claim because it had not received the functionality information. *Id.* at 13. The denial letter described the procedures and timelines for internally appealing the decision and explained that Ms. Heimeshoff could not bring an ERISA suit until her internal appeals had been exhausted. *Id.* at 14-15. It

also explained that Ms. Heimeshoff could provide additional materials in support of her appeal. *Id.*

Ms. Heimeshoff then retained a lawyer to assist with her mandatory appeal. Her lawyer contacted the Plan within the appeal period outlined in the denial stating that Ms. Heimeshoff was appealing the decision and requesting the record. *Id.* at 16-19. In response, the Plan stated that an appeal was inappropriate and that once the Plan acquired the functionality information, it would "re-open" her claim. *Id.* at 21. To ensure that, this time, the Plan would have all of the information it claimed was needed, Ms. Heimeshoff arranged to undergo a two-day functionality evaluation by a specialist. Pet. App. 8. Acquiring the specialist's evaluation and report required time. *See* JA 24-25.

After Ms. Heimeshoff obtained and submitted the evaluation and report, as well as other additional medical records, on November 29, 2006, the Plan again denied Ms. Heimeshoff's claim. *Id.* at 22-27. Because it had "re-opened" Ms. Heimeshoff's claim instead of permitting her to appeal the December 2005 decision, the 2006 denial letter stated that she needed to appeal the new decision before she would be able to go to court and, again, explained that she could submit additional information. *See id.* at 21, 27.

Within the time period provided for appeal, Ms. Heimeshoff again informed the Plan that she was appealing the denial of benefits and requested additional time; Ms. Heimeshoff wanted to maximize her chances of getting the denial reversed and more time was needed to accommodate the additional experts' schedules. *Id.* at 28-29. However, Ms. Heimeshoff's appeal was ultimately denied on

November, 26, 2007, more than two years after she filed her claim and approximately two years from the date proof of loss was due. *See* Pet. App. 7, 14. The appeal denial letter, which stated that it was the Plan's "final decision," explained that now Ms. Heimeshoff could bring an ERISA suit in court, but did not explain what, if any, time limits applied for doing so. JA 59.

On November 18, 2010—fewer than three years after the Plan's final denial—Ms. Heimeshoff brought this suit in federal court, challenging the Plan's adverse benefit decision. *Id.* at 1, 60.

2. Proceedings Below

In November 2010, Ms. Heimeshoff filed this ERISA suit in federal district court challenging the Plan's denial of disability benefits under § 502(a)(1)(B), alleging that the decision to deny her benefits was arbitrary and capricious, that the Plan violated the terms of the plan documents, and that the Plan violated ERISA's requirements that the Plan follow a particular process and issue certain notices. *Id.* at 76-78. She also alleged, under § 502(a)(2), that the Plan breached its fiduciary duty and sought further equitable relief under § 502(a)(3). *Id.* at 78-82.

In response, Respondents moved to dismiss Ms. Heimeshoff's suit as time-barred. Pet. App. 5. They argued that Ms. Heimeshoff's claim was untimely because it was filed more than three years after proof of loss was due. *Id.* at 13. The district court agreed, rejecting Ms. Heimeshoff's argument that, among other things, the limitations period in the plan was unenforceable because the time for filing suit was not laid out in the denial letters, in violation of U.S. Department of Labor regulations. *Id.* at 15-18.

Ms. Heimeshoff appealed to the U.S. Court of Appeals for the Second Circuit. She argued that, under federal law, a claim accrues and the limitations period begins to run when the plaintiff is able to file to her claim in court—here, when the Plan denied her final appeal in November 2007. Appellant's Br. 36-44. Therefore, she argued, even assuming the validity of the three-year limitations period, her claim was timely. In addition, Ms. Heimeshoff argued that because the Plan violated the regulatory notice requirements, which required the Plan to notify Ms. Heimeshoff of her deadline to file in court, the limitations period was unenforceable, or, in the alternative, the limitations period should be tolled. *Id.* at 20-38, 48-51.

The Second Circuit rejected Ms. Heimeshoff's arguments in a summary order. Pet. App. 1-2. The court relied on its prior decision in *Burke v. PriceWaterHouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76 (2d Cir. 2009), which held that a limitations period could run before a claimant can bring suit. Pet. App. 3. Ms. Heimeshoff then sought certiorari, which this Court granted.[4]

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[4] In their opposition brief, Respondents argued that "petitioner's focus on 'accru[al]' is misleading," because that term refers only to when "a beneficiary's right to bring suit under Section 502(a) arises." BIO at 10-11. That is wrong. "Accrual" can refer both to the time a statute of limitations starts running on a claim and to the time a claim is ripe to be filed in court. *See, e.g.*, *Reiter v. Cooper*, 507 U.S. 258, 267 (1993) (discussing both uses). This case is about the former—when a claim accrues for limitations purposes—not the latter. *See* Pet. at i ("When should a statute of limitations accrue for judicial review of an ERISA disability adverse benefit determination?").

SUMMARY OF ARGUMENT

The question in this case is whether the statute of limitations for challenging benefit denials under § 502(a)(1)(B) of ERISA starts to run when the benefits are finally denied, or whether, as Respondents contend, the limitations period begins to run whenever the plan says it does, unless a federal court decides that the plan's accrual provision is not "reasonable" in the specific case before it. Respondents agree that a federal denial-of-benefits claim cannot be filed in court until the plan-provided internal remedies have been exhausted. BIO at 11. They argue, however, that ERISA allows them to start the limitations clock running on that claim at some time before exhaustion—here, at the time proof of loss is due, near the beginning of what can prove to be a very lengthy internal claims process, a process that could outlast the entire limitations period.

Nothing about Respondents' approach—neither its attempt to manipulate the accrual date of a federal denial-of-benefits cause of action nor its extra-contractual case-by-case "reasonableness" inquiry—can be squared with ERISA, blackletter federal accrual law, or state law.

1. It has been settled law for nearly two centuries that, unless Congress affirmatively specifies otherwise in the statute itself, the limitations period on a federal claim does not begin to run until that claim can be filed in court. *See Clark v. Iowa City*, 20 Wall. 583, 589 (1875) ("All statutes of limitation begin to run when the right of action is complete. . . .")

A beneficiary's denial-of-benefits claim under § 502(a)(1)(B) incorporates this standard rule and accrues for limitations purposes only when an ERISA plan finally denies a beneficiary's claim for benefits, which is when a beneficiary can actually file her claim in court. Although Congress can pass a statute that "create[s] a cause of action that accrues at one time for the purpose of calculating when the statute of limitations begins to run, but at another time for the purpose of bringing suit," it may only achieve this "odd result" by explicitly saying so in the legislation itself. *Reiter*, 507 U.S. at 267. No such command can be found anywhere in ERISA for § 502(a)(1)(B) claims challenging a denial of benefits.

This is the only rule that makes sense in light of ERISA's mandatory exhaustion requirement, which requires that beneficiaries pursue their benefits claims through plan-provided internal procedures before seeking any judicial review. Indeed, a § 502(a)(1)(B) claim like the one at issue here challenges a plan's (allegedly) *wrongful* denial of benefits—a claim that does not come into existence until the plan actually denies benefits. A contractual accrual provision, like Respondents', that starts the clock ticking on a beneficiary's claim before that claim even exists, gives fresh meaning to the word Kafkaesque.

2. The Second Circuit lost sight of this rule based on three mistakes of law. First, it believed that state law, not federal law, governs the question of accrual. This was error. *See Wallace v. Kato*, 549 U.S. 384, 388 (2007). Second, it erred in pointing to the state insurance law framework, which permits proof-of-loss accrual dates for insurance claims in a context where there is no mandatory exhaustion

requirement. That framework is not analogous and cannot be used as a model for how ERISA accrual should work. Third, it ignored the well-established rule under both state and federal law that, where an administrative or other proceeding must be completed before a plaintiff can file suit, the limitations period for filing suit is tolled while the plaintiff pursues the prerequisite proceeding.

3. Finally, Respondents' approach undermines ERISA's carefully crafted remedial regime. Starting the clock ticking on a denial-of-benefits claim before exhaustion of the internal resolution process, and keeping it running while that process is ongoing, thwarts ERISA's interlocking and mutually reinforcing benefit-determination process. *See White v. Sun Life Assurance Co. of Canada*, 488 F.3d 240, 247-48 (4th Cir. 2007). It discourages comprehensive and good-faith internal resolution of disputes and creates the very real risk that a beneficiary's right to file a federal denial-of-benefits claim will be completely eliminated. Moreover, because the limitations period would vary for every claimant, in every case, depending on various factors, including the length of the mandatory internal review process, Respondents' rule unavoidably sows uncertainty and unpredictability.

Faced with the untenable possibility that its approach will lead to the extinguishment of the federal denial-of-benefits claim, Respondents proffer a truly unworkable "solution"—an extra-contractual "reasonableness" requirement, read into every ERISA plan, that compels a judge to evaluate the running of a plan's limitations period on a case-by-case basis according to a standard that has never been defined at all, let alone with any precision. *See*

id. at 248. Under this regime, nobody (not even the plan administrator) would have any idea at the outset how much time a beneficiary would have to file a federal court challenge to a denial of benefits or if the running of the limitations clock would ultimately be enforceable. That approach violates ERISA's written plan requirements and this Court's repeated admonition that ERISA "is built around reliance on the face of written plan documents." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995).

At its core, Respondents' approach "leaves the law more uncertain, more unpredictable than it found it." *Glenn*, 554 U.S. at 122 (Roberts, C.J., concurring). No stakeholder benefits from such a regime.

ARGUMENT

I. The Respondents' Accrual Rule Contravenes Federal Law.

A. The Limitations Period on a Federal Claim Begins to Run Only When a Plaintiff Can Bring Her Claim in Court.

It has been the settled rule—"since the 1830s," *Gabelli v. SEC*, ___ U.S. ___, 133 S. Ct. 1216, 1220-21 (2013)—that, for limitations purposes, a federal cause of action does not accrue until "the plaintiff has a complete and present cause of action." *Bay Area Laundry & Dry Cleaning Pension Trust Fund v. Ferbar Corp. of Cal., Inc.*, 522 U.S. 192, 201 (1997) (internal citations omitted). That straightforward rule does not permit a limitations clock to run on a federal claim until "the plaintiff can file suit and obtain relief." *Id.* at 201; *see also Clark*, 20 Wall. at 589 ("All statutes of limitation begin to run when the

right of action is complete. . . ."); *Wallace*, 549 U.S. at 388 (reiterating *Bay Area Laundry*'s rule).

This rule applies to statutory causes of action that do not otherwise identify a specific accrual date. As this Court has held time and again, when Congress does not specifically identify an accrual date for a federal cause of action, it is the "standard rule that the limitations period commences when" the plaintiff "can file suit and obtain relief," and not, as Respondents would have it, at any time before. *Bay Area Laundry*, 522 U.S. at 201; *see Graham Cnty. Soil & Water Conservation Dist. v. United States ex rel. Wilson*, 545 U.S. 409, 418 (2005) (explaining that the Court has "repeatedly recognized that Congress legislates against the standard rule that the limitations period commences when the plaintiff has a complete and present cause of action"); *see also TRW, Inc. v. Andrews*, 534 U.S. 19, 37 (2001) (Scalia, J., concurring) ("Congress has been operating against th[is] background rule . . . for a very long time."); *Spannaus v. U.S. Dep't of Justice*, 824 F.2d 52, 56-57 n.3 (D.C. Cir. 1987) (noting that it is "virtually axiomatic" that a statute of limitations "cannot begin to run against a plaintiff *before* the plaintiff can maintain suit in court" (emphasis in original)).

For federal claims, like the one at issue here, that are expressly conditioned on the exhaustion of a mandatory pre-suit process—administrative or private—this rule means that a limitations clock does not start running on the claim until that process is complete. That is true of virtually every federal statutory claim that is predicated upon the

exhaustion of mandatory pre-suit procedures.[5] *See, e.g.*, *Bowen v. City of New York*, 476 U.S. 467, 478 (1986) (Social Security Act) (limitations period for filing Social Security Act claims in court begins to run after administrative remedies have been exhausted); *Spannaus*, 824 F.2d at 56-57 (FOIA) ("Tautologically, a suit cannot be maintained in court—and a cause of action does not first accrue—until a party has exhausted all administrative remedies whose exhaustion is a prerequisite to suit."); *U.S. Dep't of Labor v. Old Ben Coal Co.*, 676 F.2d 259, 261 (7th Cir. 1982) (the Coal Act) ("In the context of the Coal Act the district court claim accrues only after the administrative proceeding has ended . . . .").[6]

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[5] As explained *infra* in Part II.C, the only exceptions to the rule that the limitations period begins to run when pre-suit procedures are exhausted are regimes in which courts apply tolling rules to stop the running of the limitations clock until the administrative or internal process is complete. *See, e.g.*, *Walker v. Sheahan*, 526 F.3d 973, 978 (7th Cir. 2008) (prisoner claims brought under the Prison Litigation Reform Act).

[6] *See also Muwekma Ohlone Tribe v. Salazar*, 708 F.3d 209, 218-19 (D.C. Cir. 2013) (Indian Reorganization Act) ("Muwekma's termination of recognition claim was subject to administrative exhaustion and thus did not accrue until . . . Interior issued its Final Determination."); *Ortiz v. Sec'y of Def.*, 41 F.3d 738, 743 (D.C. Cir. 1994) (Army Board for Correction of Military Records Act) ("Although *Spannaus* is not controlling . . . its logic is unassailable: a statute of limitations will not normally begin to run until a party has acquired the right to initiate the proceeding covered by the limitations period."); *Wind River Mining Corp. v. United States*, 946 F.2d 710, 716

All these cases recognize, implicitly or explicitly, that it is nonsensical to start a limitations clock running before exhaustion when exhaustion is mandatory. That logic does not apply, however, where the pre-suit process is *not* mandatory. In such cases this Court has made clear that a limitations clock *can* begin to run before complete exhaustion. *See Johnson v. Ry. Express Agency, Inc.*, 421 U.S. 454, 461 (1975) (limitations clock begins running at time of injury for § 1981 claim because, unlike his Title VII claim, "Petitioner freely concedes that he could have filed his § 1981 action at any time after his cause of action accrued"); *cf. McMahon v. United States*, 342 U.S. 25, 27-28 (1951) (seaman's Suits in Admiralty Act claim begins running from date of injury because administrative claim, if not rejected within 60 days, is "presumed to have been administratively disallowed and the claimant shall be entitled to enforce his claim [in court]"). These cases only underscore the rule that, where a plaintiff *is* required to exhaust before suit, the clock on his

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(9th Cir. 1991) (Federal Land Policy and Management Act) (holding that a "substantive challenge to an agency's decision" accrues for limitations purposes upon the completion of the administrative proceedings); *United States v. Meyer*, 808 F.2d 912, 916 (1st Cir. 1987) (Export Administration Act) ("All of the analogous authority appears to concur with the general rule that if disputes are subject to mandatory administrative proceedings before judicial action may be taken, then the claim does not accrue until their conclusion.") (internal quotations omitted).

judicial claim does not start until that mandatory process is complete.[7]

B. An ERISA Denial-of-Benefits Claim Under § 502(a)(1)(B) Hews to this Standard Rule.

ERISA operates no differently from all these examples. The standard rule of accrual applies. As this Court has explained, a § 502(a)(1)(B) claim challenges the "*wrongful denial* of benefits." *Varity*, 516 U.S. at 512 (emphasis added); *see also Pilot Life*, 481 U.S. at 52 (characterizing claim as one for "*improper* processing of a claim for benefits" (emphasis added)). Because a plan's improper denial gives rise to the civil claim, it defies logic to assert that the claim accrues—and the limitations period

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[7] This rule has also been applied to claims under § 301 of the Labor Management Relations Act (LMRA), after which ERISA's § 502(a) enforcement scheme was modeled. *See UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 346 n.7 (1999). Section 301 claims arise when an employer has violated the terms of a collective bargaining agreement (CBA) and the employee's union has failed in its duty to represent the employee fairly. 29 U.S.C. § 185; *see also DelCostello v. Int'l Bhd. of Teamsters*, 462 U.S. 151, 163-72 (1983). In such cases, it is well established that the clock on the employee's claim does not begin to run until either the employee has exhausted the CBA's grievance process or it becomes clear that exhaustion is impossible or would be futile. *See, e.g.*, *Konen v. Int'l Bhd. of Teamsters*, 255 F.3d 402, 406 (7th Cir. 2001) (employee's LMRA claim accrues when "a final decision on [his] grievance has been made or from the time [he] discovers, or in the exercise of reasonable diligence should have discovered, that no further action would be taken on his grievance"); *Chapple v. Nat'l Starch & Chem. Co. & Oil*, 178 F.3d 501, 505 n.4 (7th Cir. 1999).

starts running—before that allegedly improper decision is made.

So reasoned this Court in *Crown Coat Front Co. v. United States*, 386 U.S. 503 (1967), which rejected an effort to start the clock running on a federal claim before the wrongful act has taken place or, in other words, before injury. There, this Court held that a contractor's federal cause of action did not—indeed, could not—accrue for limitations purposes until the administrative process was complete because "[t]he focus of the court action is the validity of the administrative decision, . . . until that decision is made . . . [the contractor] cannot know what claim he has or on what grounds administrative action may be vulnerable." *Id.* Exactly the same logic applies to a § 502(a)(1)(B) denial-of-benefits claim.

To see why Respondents' rule can yield illogical results, consider the case of a beneficiary who initially receives disability benefits from her plan only to have them terminated several years later. If the limitations period really runs from the proof-of-loss date, as Respondents contend it should, then the clock is running on a beneficiary's denial-of-benefits claim while the beneficiary is actually receiving benefits. This scenario has occurred more than once. *See, e.g.*, *Abena v. Metro. Life Ins. Co.*, 544 F.3d 880 (7th Cir. 2008); *Skipper v. Claims Servs. Int'l*, 213 F. Supp. 2d 4 (D. Mass. 2002).

This Court has already rejected an effort to start the clock running on a claim under ERISA at some point before the claim becomes ripe for filing in federal court. *See Bay Area Laundry*, 522 U.S. at 200-01. There, though Congress supplied a limitations period for the claim—a pension plan's action to recover unpaid withdrawal liability under

the Multiemployer Pension Plan Amendments Act (MPAAA)—it did not specify when the claim accrued for purposes of the limitations period. *Id.* at 201. The Ninth Circuit held that the limitations period began to run from the date the employer withdrew from the plan, or, in other words, "at a time when the [plaintiff] could not yet file suit." *Id.* at 200. This Court rejected that result as "inconsistent with basic limitations principles," concluding that, because a plaintiff could not maintain an action under the MPAAA until an employer missed a scheduled withdrawal payment, the limitations period "does not begin to run until that time." *Id.* at 200-01.

So too here. Like the Ninth Circuit in *Bay Area Laundry*, the Second Circuit held that, under ERISA, the limitations period for a § 502(a)(1)(B) claim challenging the denial of benefits could legally commence "from the time that written proof of loss was due under the plan" Pet. App. 3, or, in other words, "at a time when the [plaintiff] could not yet file suit." *Bay Area Laundry*, 522 U.S. at 201. But ERISA affords "no basis to obtain relief" on that date, *id.*, so the lower court was wrong. A beneficiary simply has no claim until her plan denies her claim for benefits, and the limitations period (whatever length it is) cannot begin to run until then. *Cf. Meyer*, 808 F.2d at 919 (refusing to "read this sort of anomaly into [a] statutory scheme" requiring administrative exhaustion absent "some clear demonstration that Congress intended" to create the possibility "of such a grotesque analemma").

Congress can, of course, pass a statute that "create[s] a cause of action that accrues at one time for the purpose of calculating when the statute of limitations begins to run, but at another time for the

purpose of bringing suit." *Reiter*, 507 U.S. at 267. Although rare, it has done so before, *see Dodd v. United States*, 545 U.S. 353, 359-60 (2005), though never, to Petitioner's knowledge, in the context of a statute, like ERISA, that imposes a mandatory internal pre-suit process which itself forms the basis of the federal claim. But, although Congress is free to provide "such an odd result," *Reiter*, 507 U.S. at 369, it may do so only by explicitly saying so in the statutory text. *TRW, Inc.*, 534 U.S. at 37 ("When [Congress] has wanted us to apply a different rule, . . . it has said so.") (Scalia, J., concurring); *Cloer v. Sec'y of Health & Human Servs.*, 654 F.3d 1322, 1333 (Fed. Cir. 2011) (a challenger faces a "heavy burden of proving that Congress intended the odd result of breaching the firm default rule," and "meant to divorce the date of accrual of [a] cause of action from the date that the statute of limitations begins to run"). No such command can be found anywhere in ERISA for § 502(a)(1)(B) claims challenging a denial of benefits.

Tellingly, however, ERISA does include specific accrual dates for fiduciary breach claims arising under § 502(a)(2). *See* 29 U.S.C. § 1113. Thus, Congress knew how to depart from the settled rule by using the type of clear statement required by this Court's precedents. That Congress deliberately decided not to do that for the claim at issue here speaks volumes; that choice may not be tampered with. *Russell*, 473 U.S. at 147 ("We are reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA."); *cf. Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 837-38 (1988) ("[W]e are hesitant to adopt an interpretation of a congressional enactment which

renders superfluous another portion of that same law.").

Unhappy with the settled rule that a denial-of-benefits claim accrues—for limitations purposes—when a beneficiary can file her claim in federal court, Respondents simply propose a different one: that where "nothing in [the statute] precludes" a party from altering an accrual date for limitations purposes, such an alteration is permissible. BIO at 22. That rule turns the settled law on its head and must be rejected. *See Crown Coat*, 386 U.S. at 514; *see also TRW, Inc.*, 534 U.S. at 38 (Scalia, J., concurring) ("To apply a new background rule to previously enacted legislation would reverse prior congressional judgments; and to display uncertainty regarding the current background rule makes all unspecifying new legislation a roll of the dice.").

II. State Law Cannot Justify an Accrual Provision that Runs the Limitations Period on an ERISA Denial-of-Benefits Claim While a Beneficiary Is Exhausting Her Internal Remedies.

Nothing in state law justifies the Second Circuit's conclusion that an ERISA plan can run the clock on a federal denial-of-benefits claim while a beneficiary pursues her plan's mandatory pre-suit process. In upholding an ERISA plan's accrual provision doing this, the Second Circuit made a series of related errors: (1) it improperly concluded that state law, not federal law, governs accrual under ERISA; (2) it misguidedly looked to provisions of state insurance law as proof that ERISA plans could run their limitations period from when proof of loss is due; and (3) it failed to take into account state tolling law that would toll the running of the limitations clock until a beneficiary's claim could be filed in court, after

exhausting the internal procedures. Any one of these errors is reason enough to reject the Second Circuit's rule.

A. Federal, Not State, Law Governs When the Limitations Period for an ERISA Claim Begins to Run.

The Second Circuit's first mistake was in relying on its controlling predecessor *Burke*, 572 F.3d 76, which conflated the source of law governing *accrual* of a federal claim with the law governing the application of a *limitations period*. In the *Burke* court's view, both are governed by reference to state law. *See, e.g.*, *id.* at 79 (concluding that an ERISA plan could alter the accrual date because "here, as allowed under New York law, the Plan specifies the limitations period will begin to run at a different time than when a claimant could bring a federal action"). Thus, according to the Second Circuit in *Burke*, the fact that *state law* permitted alteration of accrual dates was "reason to infer the odd result that the limitations period began to run prior to the time [a beneficiary] could file suit in federal court." *Id.* (internal citations omitted); *see also* Pet. App. 3 ("In this Circuit, a statute of limitations specified by an ERISA plan for bringing a claim under 29 U.S.C. § 1132 may begin to run before a claimant can bring a legal action.") (citing *Burke*, 572 F.3d at 81).

This conclusion, however—that state law governs both a federal claim's limitations period *and* its accrual date for purposes of measuring the limitations period—is mistaken. Accrual is a question of *federal* law, not state law. *Wallace*, 549 U.S. at 388. So, where a federal statute is silent on both the limitations period and the accrual date for a specific federal cause of action, courts (in general)

must "look[] to the law of the State in which the cause of action arose . . . for the length of the statute of limitations." *Id.* at 387. "[T]he accrual date," in contrast, "is a question of federal law that is *not* resolved by reference to state law." *Id.* at 388 (emphasis in original). *See also Miller v. Fortis Benefits Ins. Co.*, 475 F.3d 516, 520 (3d Cir. 2007) ("[T]he accrual date for federal claims is governed by federal law, irrespective of the source of the limitations period.").

B. The State-Law Insurance Framework Is Inapposite Because, Unlike ERISA, It Does Not Require Exhaustion.

Compounding its legal mistake, the Second Circuit also erred in its reading of state-law accrual rules. Both the Second Circuit and Respondents claim that state insurance proof-of-loss provisions show that the Plan's approach here is both widely accepted and sound public policy. *See Burke*, 572 F.3d at 81; BIO at 3 ("In the vast majority of States, insurance contracts are required by law to include proof-of-loss limitations language similar to [the Plan's] provision." (citing *Wetzel*, 222 F.3d at 647 n.5)). This reading ignores an important fact about these state-law provisions that render them inapposite in the ERISA context: They are not employed in conjunction with a lengthy and open-ended mandatory administrative exhaustion period. That fact makes all the difference between a context in which an accrual provision tied to the proof-of-loss date makes sense and one in which such a provision tramples on the rights of beneficiaries.

Consider, for example, the state-law accrual provision cited in *Burke*. 572 F.3d at 78-79. Under New York insurance law, a policyholder must only

wait a short period—just 60 days from when she files a claim under her policy—before suing in court to recover under the policy. *See id.* (discussing N.Y. Ins. Law § 3221(a)(14)). Coupled with New York's two-year limitations period, a policyholder knows with certainty that she will have one year and 10 months from the date proof of loss is due to bring her claim in court. None of this certainty exists in the ERISA benefits process. No one can consult the plan documents and know precisely how much time a beneficiary will have to file a denial-of-benefits claim because whether and when the benefits will be denied depends on the contents, outcome, and length of the internal review process—which, in turn, depend on a host of variables that cannot be predicted in advance.

Given these differences, state law accrual provisions that start the limitations clock running when proof of loss is due have no place in the context of ERISA—and the Second Circuit's conclusion to the contrary must be rejected.

C. Even If the Limitations Period Begins to Run at Proof-of-Loss, Under Both State and Federal Law, the Limitations Period Is Tolled During Mandatory Exhaustion.

Finally, even if the Second Circuit were right that a plan could alter ERISA's accrual date and start the limitations clock ticking before a beneficiary has completed the mandatory internal process, it would be wrong not to follow state-law tolling rules. When federal statutes do not specify a limitations period, as for ERISA in denial-of-benefits claims, federal courts borrow analogous state limitations periods. *Johnson*, 421 U.S. at 462. Along with those limitations periods, federal courts also borrow the

state tolling rules. *Hardin v. Straub*, 490 U.S. 536, 539, 540 (1989). And in virtually every state, when there is a mandatory administrative or other process the potential plaintiff must exhaust before filing suit, the limitations period does not run while the process is pending.

All relevant sources—treatises, state laws, and analogous federal settings—bear this out. It is standard textbook law that, where an administrative or other proceeding must be completed before a plaintiff can file suit, the limitations period for filing suit is tolled while the plaintiff pursues the required proceeding. Corman, Limitations of Actions § 8.4.1, at 15-16 (1991); 51 Am. Jur. 2d Limitation of Actions § 186 (2013). *See also Harris v. Alumax Mill Prods., Inc.*, 897 F.2d 400, 404 (9th Cir. 1990) ("[T]olling is most appropriate when the plaintiff is *required* to avail himself of an alternate course of action as a precondition to filing suit." (emphasis in original) (internal quotations omitted)); *Trent v. Bolger*, 657 F.2d 837, 659 (4th Cir. 1988) ("[W]hen an employee is required to exhaust an administrative remedy, the applicable limitations period . . . is tolled pending the exhaustion of that administrative remedy.").

State courts consistently follow this rule. For example, in several states, broad statutory or judicial tolling rules apply in all cases in which a pre-suit proceeding is required. As the California Supreme Court has explained, "[i]t has long been settled . . . that whenever the exhaustion of administrative remedies is a prerequisite to the initiation of a civil action, the running of the limitations period is tolled during the time consumed by the administrative proceeding." *Elkins v. Derby*, 525 P.2d 81, 83-84 (Cal. 1974) (interpreting Cal. Civ. Pro. Code § 356). *See*

735 Ill. Stat. Comp. 5/13-216 (when commencement of an action is delayed by statutory prohibition, the limitations period does not run during the delay); *Ragland v. Alpha Aviation, Inc.*, 686 S.W.2d 391, 393 (Ark. 1985) (explaining that where an individual is prevented from filing a claim by the pendency of other proceedings, that pendency will toll the statute of limitations); *Allard*, 644 A.2d at 72 (endorsing general rule that tolling applies when an administrate proceeding is a prerequisite to a civil action and rejecting the argument that a plaintiff ought to file a suit and seek a stay instead); *W.V. Pangborne & Co. v. N.J. Dep't of Transp.*, 562 A.2d 222, 228 (N.J. 1989) (tolling requires that the prerequisite proceedings be mandatory).

Other states' laws address this type of tolling in the context of specific mandatory pre-suit proceedings. In Georgia, for example, limitations periods are tolled when the pendency of a worker's compensation claim prohibits an employee from filing suit. *Butler v. Glen Oak's Turf, Inc.*, 395 S.E.2d 277, 280 (Ga. Ct. App. 1990). Likewise, the Supreme Court of Michigan has held that statutes of limitation are tolled while a party exhausts mandatory grievance procedures provided in collective bargaining agreements. *Am. Fed'n of State, Cnty. & Mun. Emps., AFL-CIO, Mich. Council 25 & Local 1416 v. Highland Park Sch. Dist. Bd. of Educ.*, 577 N.W.2d 79, 86-91 (Mich. 1998). The same tolling rule applies to habeas claims in Kansas, Kan. Stat. Ann. § 60-1501, and discrimination claims with mandatory pre-suit proceedings in Minnesota, *Sigurdson v. Isanti Cnty.*, 433 N.W.2d 910, 913 (Minn. Ct. App. 1988) *aff'd* 448 N.W.2d 62 (Minn. 1989).

Connecticut law does the same: In every instance where there is a mandatory pre-suit proceeding and the claim accrues before the proceeding has concluded, the limitations period for the later-filed suit is tolled during the pendency of the earlier proceeding. *See Perzanowski v. City of New Britain*, 440 A.2d 763, 765 (Conn. 1981). For example, in the underinsured motorist insurance context, the limitations period is tolled while the potential plaintiff exhausts the limits of liability under the tortfeasor's policy—a process that must be completed before a motorist can file a claim on his or her underinsurance policy. Conn. Gen. Stat. § 38a-336(g).[8] Similarly, Connecticut law provides for the tolling of the limitations period for an attorney malpractice claim where the potential plaintiff does not have a complete claim until earlier litigation has concluded. *Fontanella v. Marcucci*, 877 A.2d 828, 834-35 (Conn. Ct. App. 2005). In short, under Connecticut law—as in virtually all other states—where there is a mandatory pre-suit proceeding, the limitations period is tolled for the duration of that proceeding.

This tolling rule is also found in analogous federal contexts. In *Johnson*, 421 U.S. at 460, for example, this Court held that because a plaintiff need not exhaust his Title VII administrative remedies before

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[8] Tolling under Connecticut's underinsured motorist statute comes into play only when the insurance policy sets the accrual date prior to exhaustion. Without such a policy term, the limitations period starts running for an underinsured motorist claim against the insurer when the plaintiff exhausts the limits of liability under the tortfeasor's policy—that is, when the claim can be brought in court. *Coelho*, 752 A.2d at 1066-69.

filing a § 1981 discrimination claim—that is, because administrative exhaustion was not required before he could file his claim—the limitations period for the § 1981 claim was not tolled during the administrative proceedings. *Id.* 465-66. In other words, whether or not the limitations period is tolled for the pendency of an earlier proceeding depends on whether that proceeding is a mandatory prerequisite to suit: If it is mandatory, tolling is appropriate, if not, then there is no tolling.

Federal courts also apply the principle that limitations periods are tolled while mandatory pre-suit procedures are being exhausted in the closely analogous context of § 1983 claims brought by prisoners. Just as ERISA contains no statute of limitations for § 502(a)(1)(B) claims, neither does § 1983, forcing courts to look to state statutes of limitations in both instances. *See Wilson v. Garcia*, 471 U.S. 261, 266-67 (1985). And, as in ERISA denial-of-benefits cases, the Prison Litigation Reform Act requires prisoners filing § 1983 claims challenging their prison conditions to first exhaust internal prison review processes; that is, prisoners must exhaust the prison grievance procedure before they can sue in court. 42 U.S.C. § 1997e(a). Thus, as in the ERISA context, the exhaustion requirement, absent tolling, gives the potential defendant (the prison) the opportunity to delay the mandatory internal review process until the limitations period has expired. Faced with this concern, federal courts of appeal have nearly unanimously held that the limitations periods for prisoners' § 1983 claims are

tolled while the prisoners exhaust the prisons' internal grievance systems.[9]

In other contexts, too, federal courts have recognized that limitations periods are tolled while potential plaintiffs are exhausting mandatory pre-suit proceedings. For example, the tolling rule is recognized in disputes over government contracts, *N. Metal Co. v. United States*, 350 F.2d 833, 838-39 (3d Cir. 1965), cases brought to enforce civil rights, *Bd. of Educ. v. Wolinsky*, 842 F. Supp. 1080, 1085 (N.D. Ill. 1993), and cases enforcing workers' rights, *Harris*, 897 F.2d at 404; *Trent*, 837 F.2d at 659; *Brennan v. W. Nat'l Mut. Ins. Co.*, 125 F. Supp. 2d 1152, 1156 (D.S.D. 2001); *Kolomick v. United Steelworkers of Am., Dist. 8, AFL-CIO*, 762 F.2d 354, 356 (4th Cir. 1985); *Taylor v. Standard Ins. Co.*, 28

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[9] *Gonzalez v. Hasty*, 651 F.3d 318, 323-24 (2d Cir. 2011) (following other federal circuits); *Walker*, 526 F.3d at 978 (following *Johnson v. Rivera*, 272 F.3d 519 (7th Cir. 2001)); *Brown v. Valoff*, 422 F.3d 926, 943 (9th Cir. 2005) (following other federal circuits); *Johnson v. Rivera*, 272 F.3d at 522 (applying Illinois tolling law); *Brown v. Morgan*, 209 F.3d 595, 596 (6th Cir. 2000) (following other federal circuits); *Harris v. Hegmann*, 198 F.3d 153, 158 (5th Cir. 1999) (applying Louisiana tolling law); *Jackson v. Johnson*, 950 F.2d 263, 266 (5th Cir. 1992) (applying Texas tolling law). *See also Roberts v. Barreras*, 109 F. Appx. 224, 226-27 (10th Cir. 2004) (remanding for district court to determine whether tolling was warranted under New Mexico law); *Leal v. Ga. Dep't of Corrections*, 254 F.3d 1276, 1280 (11th Cir. 2001) (reversing dismissal and remanding for district court to address tolling question). *But see Braxton v. Zavaras*, 614 F.3d 1156, 1162 (10th Cir. 2010) (finding no automatic tolling under Colorado law).

F. Supp. 2d 588, 592 n.3 (D. Haw. 1997). *See also Conley v. Int'l Bhd. of Elec. Workers, Local 639*, 810 F.2d 913, 915 (9th Cir. 1987) (Kennedy, J.) ("Equitable tolling is most appropriate when the plaintiff is required to avail himself of an alternate course of action as a precondition to filing suit."). So long as the exhaustion is mandatory, courts have consistently found that the limitations period for the court action does not run while the mandatory procedures are ongoing. *See* Corman, Limitations of Actions § 8.4.1, at 10, 15-16.[10]

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All this tolling makes sense, especially given that running the limitations period during internal review would permit the entity conducting the review to delay the proceedings until the limitations period expired. *Id.* § 8.4.1, at 16. This possibility is particularly problematic where, as in ERISA, the reviewing entity is also the potential defendant. In any event, in light of the substantial body of tolling law that exists in myriad other comparable contexts, the Second Circuit's refusal to toll the limitations

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[10] For cases applying this principal to ERISA denial-of-benefits claims, see *Zorn v. Principal Life Ins. Co.*, No. 6:09-cv-81, 2012 WL 112949, at *11-*12 (S.D. Ga. Jan. 12, 2012); *Hinojos v. Prudential Ins. Co. of Am.*, Civ. No. 10-1193, 2011 WL 7768621, at *7 (D.N.M. Oct. 19, 2011); *Amos v. Hartford Life & Accident Ins. Co.*, No. CV-08-BE-2165-M, 2009 WL 1804989, at *2 (N.D. Ala. June 24, 2009) *aff'd* 362 Fed. Appx. 48 (11th Cir. 2010); *Rodolff v. Provident Life & Accident Ins. Co.*, No. 01-CV-0768, 2002 WL 32072401, at *3-*4 (S.D. Cal. Apr. 5, 2002); *Jeffries v. Trustees of Northrop Grumman Sav. & Inv. Plan*, 169 F. Supp. 2d 1380, 1382-83 (M.D. Ga. 2001); *Wolfe v. 3M Short Term Disability Plan*, 176 F. Supp. 2d 911, 916-18 (D. Minn. 2001).

clock in this context provides yet another reason why the dismissal of Petitioner's suit was improper.

III. Respondents' Accrual Rule Undermines ERISA's Carefully Crafted Regime.

Respondents' approach not only flies in the face of the settled standard rules of accrual for federal claims and generally applicable tolling requirements, it also violates the letter and spirit of ERISA itself. By permitting plans to start the clock running on a denial-of-benefits claim before the plan has denied the claim, Respondents' rule undermines the internal benefit resolution process while simultaneously weakening ERISA's civil enforcement protections. Respondents' proposed fix to these problems—grafting an ad hoc "reasonableness" analysis onto the ERISA remedial scheme—only does further damage to the certainty-focused ERISA regime.

A. Respondents' Rule Thwarts ERISA's Remedial Scheme.

A rule that would start the clock ticking on a federal denial-of-benefits claim before that claim ever comes into existence would undermine the very backbone of ERISA's core effort to "protect [employees'] contractually defined benefits," *Russell*, 473 U.S. at 148 (internal citations omitted), by discouraging good-faith pursuit of the plan-provided internal proceedings while at the same time hamstringing the civil judicial review protections. As the court in *White* explained, Respondents' rule "would allow one remedy to undercut the other." 488 F.3d at 247-48. ERISA cannot countenance this disruption of Congress' carefully balanced remedial framework.

ERISA's mandatory internal benefits resolution process serves several important purposes. First, it

"encourag[es] resolution of benefits disputes through internal administrative proceedings rather than costly litigation." *Conkright*, 130 S. Ct. at 1649. Second, resolving disputes internally, without resort to the federal courts, "promotes efficiency," *id.*, because it allows parties to employ streamlined procedures, without formalities introduced by the judicial process. *See, e.g.*, *Woodford v. Ngo*, 548 U.S. 81, 89 (2006) ("Claims generally can be resolved much more quickly and economically in [non-judicial] proceedings . . . than in litigation in federal court."); *Amato*, 618 F.2d at 567 (by instituting an administrative claim-resolution procedure in ERISA, Congress created a "nonadversarial method of claims settlement" that minimized costs for all concerned).

Third, requiring exhaustion helps set the stage for judicial review by incentivizing parties to "develop a full factual record" and enabling courts to "take advantage of agency expertise." *Janowski v. Int'l Bd. of Teamsters Local No. 710 Pension Fund*, 673 F.2d 931, 935 (9th Cir. 1983), *vacated on other grounds*, 463 U.S. 1222 (1983). Giving a plan first-crack at resolving a beneficiary's benefit claim not only minimizes premature judicial intervention, but it also streamlines it, by ensuring that "the facts and the administrator's interpretation of the plan may be clarified for the purposes of subsequent judicial review." *Ames v. Am. Nat'l Can Co.*, 170 F.3d 751, 756 (7th Cir. 1999); *Kross v. W. Elec. Co.*, 701 F.2d 1238, 1245 (7th Cir. 1983) (ERISA's mandatory internal resolution process serves the purpose of "refining and defining the problem in given cases, [and] may well assist the courts when they are called upon to resolve the controversies.").

Under Respondents' approach, all of these key goals would be frustrated. Beneficiaries who recognize that they risk losing their ability to challenge a plan's benefits denial in court may feel compelled to prospectively protect their rights by early resort to federal court. *See, e.g.*, *Rush Prudential HMO, Inc. v. Morgan*, 536 U.S. 355, 394 n.5 (2002) (explaining that suits under § 502(a)(1)(B) include obtaining "a declaratory judgment that one is entitled to benefits"); *cf. Johnson*, 421 U.S. at 465 (noting the possibility, "although perhaps not a highly satisfactory one," that a plaintiff in a § 1981 suit "may ask the court to stay proceedings until the administrative efforts at conciliation and voluntary compliance have been completed"). That would benefit no one, including plans, which would have to defend these suits. *See Franconia Assocs. v. United States*, 536 U.S. 129, 146 (2002) ("Putting prospective plaintiffs to the choice of either bringing suit [early] or forever relinquishing their claims would surely proliferate litigation."); *cf. Northern Metal*, 350 F.2d at 839 ("The dockets of the courts are too crowded for Congress to have intended that suits must be brought while the [internal tribunal] is engaged in ascertaining the facts which will determine [whether the plaintiff has a claim].").

Moreover, Respondents' approach invites beneficiaries to shy away from good-faith efforts to resolve their benefits claims privately, especially in cases where a plan has made several requests for additional information. Worried that responding to these open-ended requests will run down the clock on her civil claim, a beneficiary might, for instance, abandon the internal appeal after initial denial. This approach would result in a suboptimal record for judicial review and would prevent the plan from self-

correcting errors during the internal appeal. This Court has previously voiced its displeasure with accrual rules that might produce this result. *Cf. Franconia*, 536 U.S. at 146 (refusing to permit the limitations clock to start ticking on a Tucker Act breach of contract claim before "the time performance is due" because, if the clock began ticking any earlier, a party "would be compelled by the looming limitations bar to forgo the usual option of awaiting the time performance is due before filing an action for breach").

That a beneficiary will be forced into one of these unpalatable choices is made more likely by the fact that a plan's internal review process can exhaust the entire limitations period. The Second Circuit dismissed this possibility, believing that "strict adherence" to the Department of Labor's regulations would alleviate the concern. *See, e.g.*, *Burke*, 572 F.3d at 80 (internal citation omitted). This conclusion is at odds with the regulations themselves, which *authorize* indefinite tolling for acquisition of additional information during both the initial review process and the appeal. *See supra* at 7-8; 29 C.F.R. § 2560.503-1(f)(4). The Fourth Circuit reached exactly this conclusion in *White*. *See* 488 F.3d at 252 ("[T]he time limits prescribed in the regulations are themselves somewhat elastic and do not apply to all of the time what would be counted against a claimant.").

Ironically, under Respondents' approach, it is the beneficiary who makes a non-adversarial, good-faith effort to resolve a benefit claim internally is most at risk of losing the right to file a civil claim. Benefit claims often produce requests for additional information, and these requests, like the internal

review process generally, take time. *See supra* 7-8. Indeed, a plan often makes multiple requests at different intervals, as occurred here. *See supra* 14-16. The process can be delayed even further by a plan's decision to re-open a beneficiary's initial benefits claim rather than allow her to appeal. *See id.* In short, a beneficiary like Ms. Heimeshoff, who complies in good faith with her plan's various requests in the hope that she can win benefits without resort to court, may very likely end up hung out to dry—with no benefits and no opportunity to obtain judicial review. An outcome like this one, that results in the "underenforcement of beneficiaries' statutory rights," squarely conflicts with ERISA. *See Russell*, 473 U.S. at 147.

The upshot is a trilemma of equally undesirable options: pursue the internal review process as thoroughly and diligently as possible and risk the possibility of losing the right to judicial review; file protectively in court, risking dismissal and potentially incurring significant costs; or race through the internal process, at the risk of creating a weak record, in an effort to ensure the right to federal-court review. Whatever the choice, Congress could not have intended that its carefully integrated remedial scheme be undermined in this way.

B. Respondents' Rule Requires an Impermissible Extra-Contractual Inquiry that Frustrates the Interests of All Stakeholders.

Respondents' suggested solution to these serious concerns—a judge-made "reasonableness" requirement read into every ERISA plan—only makes matters worse. *See* BIO at 24 (arguing that the best approach, given the possibility that a beneficiary could lose her federal claim entirely is "a

case-by-case inquiry into the reasonableness of the limitations period"). Such a requirement injects substantial uncertainty into both a beneficiary's and a plan's rights, promotes disuniformity in the application of a limitations period for federal denial-of-benefit claims, and removes the plan from the center of ERISA, replacing it with a judge's impression of what is reasonable in a particular case.

1. "[O]ne of ERISA's central goals is to enable plan beneficiaries to learn their rights and obligations at any time." *Curtiss-Wright*, 514 U.S. at 83. That goal is achieved through "a scheme that is built around reliance on the face of written plan documents." *Id.*; *see also U.S. Airways, Inc. v. McCutchen*, ___ U.S. ___, 130 S. Ct. 1537, 1548 (2013) ("ERISA's focus [is] on what a plan provides" and "is built around reliance on the face of written plan documents" (internal citation omitted)). As this Court observed in *Curtiss-Wright*, a "written plan is to be required in order that every employee may, *on examining the plan documents*, determine exactly what his rights and obligations are under the plan." 514 U.S. at 83 (internal citation omitted) (emphasis in original).

Under Respondents' "reasonableness" rule, reliance on the plan goes out the window. Neither employee nor fiduciary would, upon examining the face of the plan documents, be able to ascertain with any certainty whether the contractual accrual/limitations provision would ultimately be enforced by a court. That is so because the answer would depend, in every case, on how long the internal review process ultimately took and how much time was left on the clock—and then determining whether the amount of time left over is

"reasonable." *See, e.g.*, *White*, 488 F.3d at 249 (explaining that a "sometimes-enforcing approach . . . would disregard the written plan requirement" itself, since the "reasonableness" inquiry is "nowhere contained in [the] plan").

The uncertainty created by Respondents' "reasonableness" rule is not at all academic. Consider the case of an employee who becomes disabled and (without a lawyer) files a claim for long term disability benefits that is finally denied by her plan two years and 10 months after proof of loss was due. She seeks to challenge this denial in court. Consulting her plan documents, however, she discovers that the plan includes an altered accrual date that started her three-year limitations period running back at the time "written proof of loss was due under the terms of the plan."

How should a beneficiary in that case evaluate her potential rights to seek judicial review? For that matter, how would a plan evaluate the same scenario? Would a court uphold the plan's limitations approach or invalidate it? And, since most beneficiaries retain a lawyer only after final denial, how should the lawyer counsel his potential client? No one could be sure whether the plan's tying of the limitations period to when proof of loss is due would be valid or not. How would all of this change if, instead of two months left, there were three months, or one? How is a court to determine how much time is "reasonable" under the circumstances under all these shifting scenarios?

And what of the beneficiary who has "had his application for benefits approved, and has then been receiving benefits for a period of many years before being cut-off?" For her, the plan's accrual language is

"pure gobbledygook." *Skipper*, 213 F. Supp. 2d at 7; *Forrest v. The Paul Revere Life Ins. Co.*, 662 F. Supp. 2d 183, 191 (D. Mass. 2009) (concluding that the plan's approach offers "nothing intelligible that could fairly be said to limit the right of the insured to dispute the [benefits] termination" (internal quotations omitted)). In a case like *Skipper*, the plan's provision is in fact misleading, because it cannot possibly set forth the actual time limitation that will govern. *See White*, 488 F.3d at 249.

Imagine further that a court ultimately decides that a plan's tying of the deadline for filing suit to when written proof of loss is due is, in fact, unreasonable in a given case. How much more time should a beneficiary be entitled to receive before his claim is time-barred? *See, e.g.*, *Salisbury v. Hartford Life & Accident Co.*, 583 F.3d 1245, 1249 (suggesting that courts could fashion "a reasonable time after exhaustion of administrative remedies" but offering no guidance on what such a period might be). This Court has repeatedly made clear that ERISA is designed to prevent exactly these uncertainties, yet that is precisely what the "reasonableness" requirement demands.[11]

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[11] Respondents' effort to pay lip service to the principle of categorical plan enforcement, like the Second Circuit's, confuses the issue. *See* BIO at 11; *see also Burke*, 572 F.3d at 81 (justifying its holding in part because, "courts must not rewrite, under the guise of interpretation a term of the contract"). In reality, as Respondents themselves repeatedly acknowledge, their approach *requires* courts to evaluate these provisions—which couple a limitations period with an altered accrual date—on a "case-by-case" analysis and invalidate the ones that, in the circumstances of the particular case, the courts view as

2. Imposing an extra-contractual inquiry onto plan language that is required by statute to be clear and certain also invites a host of ancillary problems. First, satellite litigation is sure to follow concerning just what, under the circumstances of a particular case, constitutes a "reasonable" application of the running of a limitations period. *Conkright*, 130 S.Ct. at 1649-50 (cautioning against rules that "interject other additional issues into ERISA litigation" that would "increase litigation costs"). True, courts could police the outer bounds of reasonableness, by disregarding plan-specified accrual dates when a plan has taken so long to make a final determination that a claimant is left with no time to file suit. BIO at 15. But parties—and courts—would have no easy way to determine how much of a compression of the beneficiary's limitation period is too much, so they would litigate it.

Second, requiring courts to police the "reasonableness" of the running of a limitations period in every case invites disuniformity. *See Conkright*, 130 S. Ct. at 1650 (standards creating "ad hoc exceptions" are particularly disfavored because of the "uniformity problems that arise"). One court might believe that three months left after final denial is reasonable while another might disagree. A "patchwork of different interpretations" will develop for cases that come nearest to crossing from reasonable to unreasonable (whatever these terms mean). *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987). That result, as this Court made clear,

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unreasonable. BIO at 12, 24. That admission deals a fatal blow to any suggestion that what is at stake here is an "enforce-the-terms-of-the-plan" rule.

"would introduce considerable inefficiencies in benefit program operation." *Id.* At its core, then, Respondents' approach "leaves the law more uncertain, more unpredictable than it found it." *Glenn*, 554 U.S. at 122 (Roberts, CJ, concurring). The Court should reject this untenable result.

CONCLUSION

The judgment below should be reversed and the case remanded for proceedings on the merits of Ms. Heimeshoff's claims.

Respectfully submitted,

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