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 *AMICUS CURIAE* OF DRI - THE VOICE OF THE DEFENSE BAR IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICUS CURIAE*[1]

DRI - The Voice of the Defense Bar ("DRI") is an international organization of more than 22,000 attorneys engaged in the defense of civil litigation. DRI is committed to enhancing the skills, effectiveness, and professionalism of defense attorneys. Consistent with this commitment, DRI seeks to address issues germane to defense attorneys, to promote the role of the defense attorney, and to improve the civil justice system. DRI has long supported efforts to make the civil justice system more fair and efficient.

To promote these objectives, DRI participates as amicus curiae in cases, such as this one, that raise issues of import to its membership, to their clientele and to the judicial system. The correct application of statutes of limitations is critical to the orderly administration of justice in civil litigation. Based on the extensive practical experience of its members and their clients, DRI is uniquely suited to explain why this Court should affirm the Second Circuit's decision in this case. The Second Circuit decision is consistent with the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §1001, et. seq. ("ERISA"), with applicable Department of

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[1] Letters of consent have been filed with the Clerk. Pursuant to Supreme Court Rule 37.6, *amicus curiae* states that no counsel for a party has written this brief in whole or in part, and that no person or entity, other than the *amicus curiae*, its members or its counsel, has made a monetary contribution to the preparation or submission of this brief.

Labor ("DOL") regulations and with this Court's holdings.

INTRODUCTION AND SUMMARY OF ARGUMENT

ERISA does not establish a limitations period for filing actions under Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), to recover benefits payable by a plan ("Claims for Benefits").[2] For years, the operative rule has been that the language of the Plan determines the time within which Claims for Benefits may be filed in court. For an equally long time, courts faced with Plans that are silent on the issue generally have applied the limitations period specified in the most analogous limitations statute of the state in which the case is filed. *See Burke v. PriceWaterhouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 78 (2d Cir. 2009).

Plan documents commonly contain a Claims for Benefits limitations period in order to provide certainty and promote consistency. Otherwise, plans with participants or beneficiaries in multiple states could be required to apply different limitations periods under the same plan.

In harmony with the dual objectives of certainty and consistency, Plan terms often specify the date on which the limitations period begins to run. Typically, such provisions require the limitations period to run from a fixed and determinable date.

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[2] The sole limitations period recited in ERISA is Section 413 which prescribes a limitations period for claims of breach of fiduciary duty and does not apply to this case. 29 U.S.C. §1113.

Settled principles support the Second Circuit's judgment in this case. First, the clear terms of a plan must be upheld. *U.S. Airways, Inc. v. McCutchen,* 133 S. Ct. 1537 (2013). Second, plan sponsors have substantial leeway in designing plans as they see fit. *See generally Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). Moreover, and more specifically, reasonable contractual limitations periods are enforceable in accordance with their terms. *See Order of United Commercial Travelers v. Wolfe*, 331 U.S. 586 (1947). For precisely these reasons, Plan provisions establishing the starting date for a contractual limitations period should be upheld even when the period begins prior to the conclusion of the administrative process; doing so is consistent with the principle that courts should not re-write unambiguous plan terms.[3]

In seeking a different result, petitioner urges the Court to disregard these well established principles. There is no merit to petitioner's contention that it is *per se* contrary to ERISA for a Plan to prescribe a

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[3] *See, e.g., Burke,* 572 F.3d at 79 (enforcing a contractual limitations period beginning three years after "proof of loss" was required); *Rice v. Jefferson Pilot Fin. Ins. Co.*, 578 F.3d 450, 456 (6th Cir. 2009) (same); *Harris Methodist Fort Worth v. Sales Support Servs, Inc. Emp.e Health Care Plan*, 426 F.3d 330, 337-38 (5th Cir. 2005) (same); *Doe v. Blue Cross & Blue Shield United of Wis.*, 112 F.3d 869, 875 (7th Cir. 1997) (enforcing a contractual limitations period that ran from the date of the services for which the benefits were sought); *Blaske v. UNUM Life Ins. Co. of Am.*, 131 F.3d 763, 764 (8th Cir. 1997) (enforcing a limitations period in the plan that ran three years after written "proof of loss" was required).

reasonable limitations period that begins at any time other than the date when a final denial of a claim is issued. Had Congress intended the result petitioner desires, the statute could have been written to say so expressly. It was not.

In contrast to respondents' sound arguments drawn from the text of the statute and governing regulations, the language of the Plan, and the clear directives of this Court's holdings, petitioner conjures up a series of hypotheticals that do not reflect real-world experience. Sorely lacking from the presentations of petitioner and her supporting *amici* are examples of actual claimants who faced the parade of horribles that form the foundation for petitioner's effort to have this Court re-write the contractual language of the Plan. But, the relevant terms of the Plan at issue in this case are typical and have been commonplace for years. Experience over that span of years teaches that the hypotheticals petitioner offers are unlikely ever to arise. Indeed, under the standard petitioner proposes, it is just as easy to offer far more likely counter-hypotheticals in which claimants would have *less time* to file suit than the three years from proof of claim that the Plan in this case provided. In any event, in the improbable circumstance that a future claimant would face the imagined dilemma of having a limitations period expire prior to a final adverse decision on her benefits claim, the courts' traditional equitable powers are fully capable of achieving a proper disposition. In short, there is no justification for departing from this Court's established bright-line test that reasonable Plan language controls.

The judgment of the Second Circuit should be affirmed.

ARGUMENT

THE CLEAR, UNAMBIGUOUS TERMS OF THE PLAN SHOULD NOT BE DISREGARDED OR RE-WRITTEN BY THE COURTS.

There is no dispute in this case that the clear and unambiguous language in this long term disability plan requires the Claims for Benefits limitations period to run from the date "proof of loss" is requested. And, as the court of appeals observed, the plain terms of the Plan provided ample notice and more than adequate time for petitioner to file suit after the administrative process was exhausted. Pet. App. 3-4; s*ee also, Burke,* 572 F.3d at 81.

Nor is there any dispute that similar language has been commonplace in benefits plans for many years. Despite that long history, petitioner urges this Court to depart from the Plan's express language based on the conjecture that some anomalies could result in the future. Drawing on the experience of its members and their clients in administering benefits plans, and in litigating adverse benefits decisions, DRI will focus in this amicus brief on explaining why petitioner's contentions offer an unrealistic view of the actual world in which benefits plans exist. There is no merit to the arguments of petitioner and her supporting *amici* that:

- a plan's internal claims procedures could potentially be tolled indefinitely, causing the plan's claims procedure to be open-ended, as well as

potentially causing the expiration of the limitations period prior to the exhaustion of the plan's administrative remedies. Pet. Br. 7-8.

- starting the limitations clock prior to completing the plan's internal resolution process discourages good-faith pursuit and administration of the internal claims process, encourages premature resort to federal court and promotes an increase in litigation. Pet. Br. 3, 8.

- fidelity to the contractual limitations period would be more awkward, inefficient and unpredictable than petitioner's preferred requirement (not written in the statute, the regulations, or the Plan) that a limitations period cannot begin until all internal Plan decisionmaking has concluded. Pet. Br. 3.

Petitioner's speculative arguments are not supported by law or empirical data, and should not upend the well-settled principle that the clear and unambiguous terms of a plan must be enforced as written.

A. DOL Claims Procedure Regulations Do Not Allow the Plan Administrator to Delay the Internal Claims Process Indefinitely..

ERISA Section 503 requires that the claims procedure of an employee benefit plan must provide adequate notice in writing to a participant or beneficiary whose claim for benefits has been denied. The statute also requires that the claims procedure must afford a reasonable opportunity for a full and

fair review of the decision denying the claim. 29 U.S.C. § 1133(2).

In implementing that statutory imperative, DOL's claims procedure regulations meticulously set forth the process and timetable for processing benefits claims. 29 C.F.R. § 2560.503-1. If a plan fails to establish or follow claims procedures consistent with the requirements of this regulation, the claimant will be deemed to have exhausted administrative remedies under the plan and shall be entitled to pursue legal action in connection with the claim at issue. 29 C.F.R. § 2560.503-1(l). That, alone, should suffice to refute petitioner's hypothetical concern that administrative limbo could consume the entire limitations period that a plan specifies.

Moreover, DOL's claims procedure regulations provide that the initial claims determination for disability benefits is limited to a 45-day term (subject to two 30-day extensions by the plan administrator which, if utilized, would still limit the maximum time for the plan administrator to determine an initial claim for disability benefits to 105 days). *See* 29 C.F.R. § 2560.503-1(f)(3). The period for considering the final determination on appeal is also 45 days (subject to a possible 45-day extension by the plan administrator). At both the initial stage and on appeal, the limited extensions are available only if the plan administrator determines they are necessary for reasons beyond the control of the plan, such as the failure of the claimant to provide necessary information. If a claim is initially denied because the claimant did not

provide essential information, the time is tolled for specified periods following notice to the claimant that additional information is needed. 29 C.F.R. § 2560.503-1.

The DOL's claims procedure regulations are designed to accelerate the resolution of claims. Strict terms apply to the processing of claims and the plan administrator can enlarge the time to resolve a claim only when the reasons for the extension are beyond the control of the plan. The tolling of the limitations period during the administrative claims process can, therefore, occur only as a consequence of the actions, or inactions, of the claimant. There is, accordingly, no basis for petitioner's suggestion that a plan's claims procedures can be tolled indefinitely when the plan requests more information from the claimant. Pet. Br. 8 ("open-ended"). In the fanciful hypothetical petitioner posits, the claimant – not the Plan – is the only party in a position to cause the delay; the delay is solely the result of the claimant not providing the information requested by the plan to process the claim in a timely fashion. Thus, petitioner's concern about a totally conjectural situation is contrafactual: existing regulations do not allow a plan or plan administrator to trigger an "open-ended" claims process.

Furthermore, the regulations provide that when an administrator fails to follow the plan's claims procedure, the claimant shall be deemed to have exhausted administrative remedies and the claimant can go straight to court to file her Claim for Benefits. Similarly, courts have allowed exceptions to the

exhaustion requirement when the claimant demonstrates that exhaustion would be futile or when the claimant has been denied meaningful access to the claims process. One example is when the plan's exhaustion requirements are ambiguous. *See Watts v. BellSouth Telecomms., Inc.*, 316 F.3d 1203 (11th Cir. 2003). *See also Wilczynski v Lumbermens Mut. Cas. Co.*, 93 F.3d 397 (7th Cir. 1996) (exhaustion of administrative process not required when the health plan denied a claim following the claimant suing the employer on an unrelated matter and claimant sufficiently showed that her employer's hostility arising from her suit made further review futile); *Fallick v Nationwide Mut. Ins. Co.*, 162 F.3d 410 (6th Cir. 1998) (exhaustion not required when a plan's insurer repeatedly resisted efforts by participants and regulators to conform its method for determining "usual and customary" expenses to the written terms of the plan).

In light of the safeguards against delay and administrative abuse already provided in existing regulations, as well as case law providing alternate avenues to court for claimants when the plan's internal claims procedures fail, there is no basis for the wholesale judicial revision of plan terms that petitioner seeks. Nor does the actual experience of these plans over many years offer any justification for the result that petitioner and her supporting *amici* ask this Court to impose.

B. Starting the Limitations Clock Prior to Completing the Plan's Internal Resolution Process Does Not Discourage Good-Faith Administration of the Internal Claims Process or Encourage Premature Resort to Federal Court Or Excessive Litigation.

Nor is there any empirical basis – or examples drawn from actual judicial decisions – for petitioner's assertion that allowing the limitations period to run from the date "proof of loss" is requested somehow impinges on the plan administrator's good faith in processing claims. Pet. Br. 3, 8.

ERISA does not require employers to offer employee benefit plans to employees. *See, e.g., Curtiss-Wright v. Schoonejongen,* 514 U.S. 73, 78 (1995) ("Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans"). It is counterintuitive, and certainly without any factual foundation, to suggest that an employer who voluntarily chooses to provide a benefit would then incorporate a provision specifically designed to prevent participants from obtaining the promised benefit. Indeed, the record in this case indicates that – far from being a trap motivated by anti-claimant bias – the "proof of loss" limitations period was expressly endorsed by state law, and for certain types of plans was explicitly made a requirement of state law. Conn. Gen. Stat. § 38a-483(a)(7). Nothing suggests that this limitation period is an obscure scheme to deprive participants of their benefits or

that plan administrators will not process claims in good faith because of the inclusion of this plan provision.

Similarly, there is no empirical support for petitioner's contention that plan participants would be discouraged from seeking benefits or challenging adverse benefits decisions when the plan provisions allow the limitations period to start running prior to the exhaustion of the internal administrative process. Indeed, as petitioner acknowledges, the vast majority of benefits claims are granted by plan administrators; only a small fraction result in litigation. Pet. Br. 9. This statistic necessarily includes claims that are processed by plans containing the "proof of loss" limitations language that is so commonplace and that, in fact, is required by state law in some jurisdictions. *See, e.g., Burke,* 572 F.3d at 78 n.1 (observing that state insurance law mandated a period of at least "two years following the time such proof of loss is required by the policy"). Federal courts have upheld this language for more than a decade. *See* note 3, *supra*. Despite the extensive experience of many plans, over many years, in many states, the grim outcomes that petitioner forecasts have simply not materialized.

For much the same reason, there is no warrant for the government's speculation that allowing the contractual limitations period to run from a date prior to the final denial of the claim "would encourage participants to attempt to expedite internal review by cutting short interaction with the plan and proceeding in a more truncated and adversarial way." U.S. Br. 7. Plans in which the

limitations period runs from the date "proof of loss" is required are nothing new, novel or rare. The absence of real-life examples of the consequences that the government's brief predicts should be a powerful disincentive against changing the law – and changing the express terms of the policy documents – as petitioner requests.

Finally, it is significant that judicial review of a plan's denial of benefits is generally not de novo, but applies the abuse of discretion standard and, therefore, is based on the file that was before the plan administrator. *See generally*, *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101, 110-115 (1989). Consequently, any reduction in the limitations period would not be unduly burdensome to the claimant since an ERISA Claims for Benefits case is more akin to review of an administrative record than it is to full-scale, full-discovery litigation requiring extensive preparation by the parties.

Lacking any basis for contending that "proof of loss" timing provisions have caused, or are likely to cause, a widespread problem of incorrectly denied benefits, petitioner also lacks a compelling argument that courts are ill-equipped to deal with whatever rare instance may arise. For decades, many federal courts have upheld the "proof of loss" limitations provisions challenged in this case and have successfully employed traditional principles of equitable tolling. *See, e.g.,* note 3, *supra*. This Court's holdings provide strong support for that result. *E.g., Wolfe*, 331 U.S. at 608.

C. The Rule Proposed by Petitioner Would Adversely Affect Other Benefit Plans and Programs.

A requirement that the limitations period must run from the date on which the plan formally denies the claim could actually shorten the time within which a disappointed claimant could seek judicial review. If a specified post-denial period is required, then plans could certainly cut the period from three years to one year, or even shorter. In many comparable contexts, periods as short as thirty to sixty days for review of adverse decisions are the norm. *E.g.,* Fed. R. App. P. 4(a)(1)(A)&(B); Administrative Orders Review Act, 28 U.S.C. § 2344. Surely the relevant period in this case could not be deemed unreasonable, where — even under the shortest measure — petitioner had more than a year from the denial of her claim before the contractual limitations period expired. *See* Resp. Br. 11 n. 7.

A further reason to reject petitioner's insistence on a specified post-denial period is to avoid the disruptive impact on other forms of benefits plans. In disability plans, such as the one inbvolved in this case, the filing of a claim for benefits generally occurs close in time to the events that trigger the claim and the claims process moves quickly. But that is not necessarily the case for other types of claims and other types of benefits plans that could be impacted by the decision in this case.

Under the latitude conferred by ERISA, plan sponsors are entitled to draft benefits plans that provide a reasonable measure of finality to protect against stale claims challenging administrative

decisions made and communicated to the claimant many years earlier. Consider the example of an individual who has been properly notified that he is not eligible to participate in a plan because of his employment classificiation; or not eligible for a particular level of benefits (regardless of the type of benefit offered by the plan). If the plan documents specify that any challenge to that determination must be made within a fixed period from the date of notification, then the finality afforded by that provision should not be vulnerable to a lawsuit many years later – when the underlying documents and decisionmakers are no longer available – by an individual who applies for and is denied benefits for which he was informed long ago that he was not eligible. In the rare event that the earlier eligibility determination was arguably incorrect, there is nothing unreasonable in a requirement that the statute of limitations run from the earlier date. A different rule would enable an individual to file a series of claims challenging the same eligibility decision over a lengthy period, a result flatly contrary to the reasonable language of the plan and also contrary to principles of finality on which limitations periods are based.[4]

Even if it were restricted to long-term disability benefits plans, there is no basis in law or in

[4] *See* Amy Covert & Aaron Feuer, *The Supreme Court to Opine on Use of Contractual Limitation Periods in ERISA Plans*, Bloomberg Law (2013), *available at* http://about.bloomberglaw.com/practitioner-contributions/the-supreme-court-to-opine-on-use-of-contractual-limitation-periods-in-erisa-plans/.

experience for the strict, inflexible rule petitioner proposes. Given the potential deleterious impact that rule would have in a broad array of other benefits contexts, there is even less to commend petitioner's view and even more reason to reject it.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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