No. 12-729

IN THE
Supreme Court of the United States

JULIE HEIMESHOFF,
Petitioner,
v.
HARTFORD LIFE & ACCIDENT INSURANCE CO., ET AL.,
Respondents.

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

BRIEF FOR THE AMERICAN COUNCIL OF LIFE INSURERS, AMERICA'S HEALTH INSURANCE PLANS, AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS AMICI CURIAE SUPPORTING RESPONDENTS

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QUESTION PRESENTED

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

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BRIEF FOR
THE AMERICAN COUNCIL OF LIFE INSURERS, AMERICA'S HEALTH INSURANCE PLANS, AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS AMICI CURIAE SUPPORTING RESPONDENTS

INTEREST OF THE *AMICI CURIAE*[1]

The **American Council of Life Insurers** (ACLI) is the largest life insurance trade association in the United States, representing the interests of hundreds of member companies operating here. ACLI's member companies are the leading providers of financial and retirement security products covering individual and group markets, including life, disability income, and long-term care insurance products. Indeed, its members account for approximately more than 90 percent of the life insurance industry's total assets, premiums, and annuity considerations. The life insurance policies issued by ACLI members include employer-sponsored group disability insurance policies and group life policies. The annuities issued include group annuities issued to employer-sponsored retirement plans. The vast majority of the products sold by ACLI members in the group employee benefits market are subject to the requirements of

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[1] The parties' blanket consents to the filing of *amicus curiae* briefs are on file with the Clerk. No counsel for a party authored any part of this brief; no party or party's counsel made a monetary contribution intended to fund the preparation or submission of this brief; and no person other than *amici curiae*, their members, or their counsel made a monetary contribution to the brief's preparation or submission.

the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq*.

America's Health Insurance Plans (AHIP) is the national association representing health insurance plans that provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP's members offer a broad range of products in the insurance marketplace, including health, disability, long-term care, dental, vision, and supplemental coverage. AHIP's membership includes a majority of insurers providing group disability insurance. AHIP seeks to facilitate, preserve, and increase the availability of affordable benefit coverage related to health care and disability.

The **Chamber of Commerce of the United States of America** (Chamber) is the world's largest business federation. It represents 300,000 direct members and indirectly represents the interests of more than three million businesses and professional organizations of every size and from every industry sector and region of the country. Its members include many employers that offer ERISA-governed benefit plans to their employees, as well as insurers who fund and/or administer such plans. The Chamber advocates for the interests of the business community in courts across the nation, in part by filing amicus curiae briefs in cases raising issues of national concern to its members. Many Chamber members provide benefits to employees through employee welfare benefit plans regulated under ERISA, including disability income insurance benefits that contain timing provisions like the plan term at issue

in this case. The Chamber's members place great importance on their ability to enforce the terms of ERISA plans as written, including timing provisions that guard against stale claims and contribute to providing affordable coverage.

The question presented here is whether a claim for benefits due under an ERISA plan must be asserted within the time expressly specified in that ERISA plan, which in this case is three years from the date on which the claimant was required to furnish written "proof of loss." Petitioner contends that the plan's timing rule is unenforceable in any action to recover benefits under Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), and that the three-year period may run only from the date of the plan's final adverse benefit determination. The resolution of that question will have significant implications for employee benefit plans and the insurance industry as a whole, and will affect the disposition of numerous cases beyond this one. The timing provision at the heart of the present dispute is by no means unique: it is instead a standard feature of the insurance industry, reflecting longstanding practice, and is also required by the insurance laws of nearly every State.

Because of the extensive involvement of the *amici's* members in the field of disability insurance and especially with respect to ERISA-governed group disability plans, the *amici* are well-equipped to address the purposes that the timing provision serves and the manner in which it coexists in harmony with ERISA's pre-suit exhaustion requirement. Contrary to how Petitioner portrays it—as a trap for the unwary that serves no legitimate purpose—the provision under review

serves the traditional, legitimate purposes of statutes of limitations, consistent with ERISA's statutory scheme.

SUMMARY OF ARGUMENT

This case is governed by a plain and unambiguous term of the ERISA plan in which petitioner participated: she was required to file her action to recover benefits within three years after her proof of loss was due. Petitioner cannot seek to recover "benefits due to [her] under the terms of the plan," 29 U.S.C. § 1132(a)(1)(B), if she did not comply with the plan's valid requirements for seeking benefits. Therefore, she must show that the timing requirement is invalid. But she identifies no provision of federal law that precludes ERISA plans from adopting a timing requirement like the one at issue here.

To the contrary: insurance policies have featured timing requirements tied to proof of loss for decades, since long before ERISA. Relying on a model law promulgated by the National Association of Insurance Commissioners, nearly every State *mandates* the use of timing provisions like this one in certain insurance contracts, generally including group disability insurance contracts. This body of state law has coexisted harmoniously with ERISA from the beginning.

Petitioner suggests that, *merely by creating a federal cause of action* to recover employee benefits, Congress rendered all of those State-mandated insurance provisions unenforceable in the context of employee benefits. But ERISA gives no indication that Congress was imposing some unwritten federal accrual rule. Rather, what is clear from ERISA is

that Congress affirmatively *declined* to specify a statute of limitations for benefits-recovery claims, even as it was setting a federal statute of limitations for other ERISA claims. Congress left procedural matters, such as the timing of suit, to ERISA plans themselves in the first instance.

Those procedures are potentially subject to state insurance regulation, which ERISA saves from express preemption. But petitioner does not claim that state law invalidates the timing provision in respondents' plan. To the contrary, most such timing provisions in ERISA plans are not just consistent with state law but mandated by it.

The flexibility to adopt timing provisions like this one is particularly important to ERISA plans and the insurance companies that insure or administer them. Petitioner's rule would substantially lengthen the time within which a claim for benefits can be litigated in court, and it would sever the link between the date of the insured loss and the date when the insurer can close the books on that loss. Indeed, petitioner would give every claimant a period of several years to sue *after* she finishes exhausting her remedies within the plan. That rule would affect insurance companies' decisions to reserve funds based on threatened but not yet asserted claims, which in turn could make welfare benefits like disability insurance more expensive for employees.

Petitioner's rule cannot even be justified on pragmatic grounds, as a solution to a pressing problem, because it does not respond to any genuine issue. Once the plan denied petitioner's claim for disability benefits, petitioner had no basis for waiting nearly *three years* before filing suit.

Petitioner contends that she should get the extra time for the sake of the hypothetical claimant who might need it. But petitioner cites *no case*—and it appears none exists—in which plan delays caused exhaustion to consume the entire limitations period, or even enough of the period to justify a different rule. Rather, the practical problems are with petitioner's rule, which would unnecessarily and unwisely stretch out the period for filing an ERISA action in *every* case, not just the extreme ones.

ARGUMENT

I. ERISA Contains No Provision That Supersedes Or Prohibits The Plan's Timing Rule

On the date that ERISA was enacted, most disability (and other) insurance contracts contained provisions indistinguishable from the one here: requiring the insured to sue for benefits within a certain number of years after the insured's proof of loss was due. Indeed, most States affirmatively *required* those contracts to include such terms. Congress would not have overlooked such a widespread rule during the decade of study leading up to ERISA. Yet petitioner's submission is that by creating a *federal* cause of action to recover those same benefits, Congress intentionally—but utterly silently—prohibited employee benefit plans from continuing to write that commonplace term into their contracts.

That theory lacks any support in ERISA's text, structure, or purpose. Petitioner and her *amici* point to *no* statutory language that forbids ERISA plans from tying the limitations period to the date proof of loss is due, or that sets a different rule as a matter of

federal law. Rather, they contend that something about the federal nature of the ERISA cause of action for recovery of benefits inherently precludes plan terms like this one. But Congress left many aspects of that cause of action to be defined by plan terms and state law. There is no reason to conclude that Congress quietly mandated a new and different federal rule for *this* aspect of the benefits-recovery cause of action—on which there was such a substantial body of state law at the time of ERISA's enactment.

A. The Timing Provision Has Long Been A Mandatory Feature Of Insurance Contracts

The timing provision of the policy at issue provides that no legal action may be taken against the plan "(1) sooner than 60 days after due proof of loss has been furnished; or (2) after the shortest period allowed by the laws of the state where the policy is delivered. This is 3 years after the time written proof of loss is required to be furnished according to the terms of the policy." Pet. App. 56. That provision is not respondents' innovation, nor is it exceptional. Indeed, nearly all States, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, require that this or a similar provision be included in health and/or disability insurance policies that are issued or delivered within their borders. *See Wetzel v. Lou Ehlers Cadillac Grp. Long Term Disability Ins. Program*, 222 F.3d 643, 647 & n.5 (9th Cir. 2000) (cataloguing statutes); Resp. Br. 6 & n.2.[2]

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[2] Nearly all States set the limitations period at three years, as in this case, but a few specify a longer period.

These provisions have a long pedigree. Many trace their origins at least to the Uniform Individual Policy Provisions Law Model Bill of 1950, proposed by the National Association of Insurance Commissioners (NAIC). That uniform law required policies to contain the following provision, substantially identical to the one at issue here:

> LEGAL ACTIONS: 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.

Uniform Individual Policy Provisions Law Model Bill of 1950, § 3(A)(11), *reprinted in* William E. Meyer, *Life and Health Insurance Law* app. A (1971).

The use of such provisions in the insurance industry predates the 1950 Model Bill. This Court in 1947, for example, confronted a substantially similar "standard contractual provision" that was mandated by a South Dakota statute enacted in 1919. *See Order of United Commercial Travelers v. Wolfe*, 331 U.S. 586, 612 & n.23 (1947) (citing § 3(14), c. 229, S.D.L. 1919, at 235). Both that South Dakota statute and the 1950 Model Bill apparently derive from an earlier NAIC uniform law promulgated in 1912. *See* Uniform Standard Provisions Bill of 1912, § 3(1)(14), *reprinted in Proceedings of the National Convention of Insurance Commissioners of the United States* 123 (1912) ("No action at law or in equity shall be

brought to recover on this policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of this policy, nor shall such action shall be brought at all unless brought within two years from the expiration of the time within which written proof of loss is required by the policy.").

Unsurprisingly given their long history, timing provisions of the type at issue here are typical in health and disability insurance policies today. Even where they are not mandatory as a matter of state law, many plans have adopted them as a sensible and context-sensitive rule for the administration and handling of claims.

B. Congress Adopted ERISA Against The Backdrop Of Established Practice, Including The Timing Requirement

Congress cannot have been unaware of this history when it formulated, and ultimately passed, ERISA's detailed provisions. This Court "generally presume[s] that Congress is knowledgeable about existing law pertinent to the legislation it enacts," and it will not assume that Congress was ignorant of the legal landscape "[i]n the absence of affirmative evidence in the language or history of the statute." *Goodyear Atomic Corp. v. Miller*, 486 U.S. 174, 184-85 (1988); *accord Director, OWCP v. Perini N. River Assocs.*, 459 U.S. 297, 319-20 (1983) ("We may presume that our elected representatives, like other citizens, know the law . . . ." (citation and internal quotation marks omitted)); 2A Norman J. Singer & J.D. Shambie Singer, *Sutherland Statutes and Statutory Construction* § 45:12, at 115 (7th ed. 2013) ("*Sutherland*") ("[L]egislative language will be

interpreted on the assumption that the legislature was aware of existing statutes . . . ."). That rule applies with particular force to ERISA, "the product of a decade of congressional study of the Nation's private employee benefit system." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993). Even more than usual, Congress was well aware of the contours of the terrain it was crossing in enacting ERISA.

Where ERISA is silent on a key point, therefore, the longstanding practice under state law informs its interpretation. Thus, for instance, this Court concluded that Congress did not intend to disturb state laws mandating that plans offer particular benefits, which had become "commonplace" by the time of ERISA. *See Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 742 (1985). Similarly, the Court presumed that when Congress did not specify a standard of review for benefit determinations (and when a plan also did not provide one in its plan documents), Congress intended to adhere to the state of the law as it was in 1974. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 112-13 (1989). *Accord, e.g.*, *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 367-68, 372-73 (2002) (reviewing Congress's contemporaneous understanding of the legal status of health maintenance organizations in construing the application of ERISA's insurance savings clause). In short, when Congress knew about a particular state-law practice, its "decision to remain silent concerning [that practice] acknowledged and accepted the practice, rather than prohibiting it." *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 837 (1988) (citation and internal quotation marks omitted).

Congress knew that many of the employee welfare benefits it was about to regulate consisted of insurance products, including disability insurance. By 1974, the timing provision had been mandated by uniform state insurance legislation for at least 60 years. Congress no doubt also was aware that such provisions had generally been approved by courts as valid contractual terms. *See* 16 Lee R. Russ et al., *Couch on Insurance* § 235:1, at 235-9 to -10 (3d ed. 2005) ("*Couch*") (collecting State cases); *accord, e.g.*, *Wolfe*, 331 U.S. at 610-11; *Riddlesbarger v. Hartford Ins. Co.*, 74 U.S. (7 Wall.) 386, 390 (1869); *see also Sutherland* § 45:12, at 115-20 (legislatures are presumptively aware of "judicial decisions" as well as legislative enactments).

Given that backdrop, it cannot be "assume[d] that Congress was ignorant of the substantial number of States" that required insurance policies to include provisions like the timing provisions at issue here. *Goodyear Atomic*, 486 U.S. at 185. Instead, the strongest inference to be drawn is that Congress was well aware of the timing provision and its mandatory usage by insurers as a function of state law.

C. Congress Did Nothing To Disapprove The Continued Use Of State-Mandated Timing Provisions In ERISA Plans

Petitioner contends that when Congress adopted ERISA, it silently rendered every one of these State-mandated plan provisions unenforceable. But petitioner never identifies anything in ERISA that abrogates this established type of contractual limitations period. Rather, she contends that ERISA creates a federal cause of action, so her preferred

federal accrual rule must apply. But the fact that ERISA is a federal statute does not end the analysis.

What petitioner disregards—and what separates ERISA from, say, TILA, RESPA, or USERRA—is the essential fact that under ERISA, it is the *plan terms* that govern, as a matter of federal law. That is the rule that the Second Circuit applied. *Burke v. PricewaterhouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 79, 81 (2d Cir. 2009); *see* Pet. App. 3 (following *Burke*). Petitioner derides that holding as a mistaken application of "state law" instead of federal law. Pet. Br. 30. But determining timeliness in accordance with the plan documents is not a matter of "state law" any more than awarding "benefits due . . . under the terms of the plan" is. 29 U.S.C. § 1132(a)(1)(B). Rather, following the plan terms is what *federal* law requires, unless Congress says otherwise. And while those plan terms may be *regulated*, or even mandated, by state insurance law to the extent that the plan provides insurance, *see* 29 U.S.C. § 1144(b)(2)(A), that only underscores that Congress largely kept its hands off what the parties could agree to in a benefits contract.

If a plan provision is valid, it governs. Here, petitioner cannot point to anything concrete that Congress said or did to invalidate the timing provision of respondents' plan. The plan language therefore is controlling.

1. Under ERISA, most key aspects of benefits and their administration are set by the terms of the plan

This is a claim for "benefits due . . . under the terms of the plan"; under ERISA, any question of

entitlement to benefits begins with the terms of the plan. ERISA's entire scheme is built on "reliance on the face of written plan documents." *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1548 (2013) (citation and internal quotation marks omitted). That "written instrument" must "specify[] the basis on which payments are made . . . from the plan." 29 U.S.C. § 1102(a)(1), (b)(4). And plan administrators must act in accordance with those "governing" instruments. *Id.* § 1104(a)(1)(D). It is those documents, not the statute itself, that primarily regulate how a plan participant may qualify for benefits.

In fact, ERISA "contains almost no federal regulation of the terms of benefit plans." *Metro. Life*, 471 U.S. at 732. Instead, Congress drew ERISA's provisions so as to preserve, not abrogate, employers' freedom to define what benefits will be provided and on what terms.[3] Employers thus have a wide range of options and may decide whether to offer particular types of benefits (*e.g.*, disability insurance, or vision coverage) depending on the needs of their employees. That flexibility reflects a conscious decision on Congress's part: it encourages employers to make

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[3] *See, e.g.*, *McCutchen*, 133 S. Ct. 1537, 1548 ("The plan, in short, is at the center of ERISA."); *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1876-77 (2011) (Section 502(a)(1)(B) "speaks of '*enforc[ing]*' the 'terms of the plan,' not of *changing* them") (emphasis in original); *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003) ("[E]mployers have large leeway to design [ERISA] disability and other welfare plans as they see fit."); *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) ("Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan.").

the voluntary decision to establish a benefit plan subject to ERISA. *See, e.g.*, *Conkright v. Frommert*, 130 S. Ct. 1640, 1648-49 (2010) ("ERISA represents a careful balancing between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans.") (citations and internal quotation marks omitted).

Flexibility in plan design extends not only to what benefits are due, but also to how the plan will administer those benefits. *See id.* at 1649 (explaining that Congress sought to prevent unnecessary administrative costs or litigation expenses from "unduly discourag[ing] employers from offering [ERISA] plans in the first place") (citation omitted) (second brackets in original). For example, the plan documents may authoritatively answer the procedural questions of how beneficiaries are to be designated and paid. *See Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 300-01, 303 (2009); *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001). Similarly, this Court has explained that even the standard of review that applies in a judicial action challenging the plan administrator's decisions is primarily "a matter of plan design," although to the extent the standard of review is set through insurance contracts, it may be subject to "substantive state regulation." *Rush Prudential*, 536 U.S. at 386.

Congress certainly can provide exceptions to the ordinary rule that "the agreement governs." *McCutchen*, 133 S. Ct. at 1547.[4] But this Court does

[4] *See, e.g.*, 29 U.S.C. § 1110(a) (declaring certain exculpatory provisions unenforceable).

not presume from silence that such an exception exists.

2. Congress left the timing decisions to the plan documents, consistent with State law

In creating a federal cause of action to recover benefits, Congress did not set any federal rule affecting a plan's ability to regulate the presentation and assertion of claims. Rather, Congress left those matters to the plan and, in certain respects, to state law.

Before ERISA, claims for benefits were litigated in accordance with the plan documents. *Firestone*, 489 U.S. at 112-13. Congress did not dramatically change that rule in ERISA. While Congress provided a federal cause of action and required in general terms that the plan provide some avenue for administrative review, 29 U.S.C. §§ 1132(a)(1)(B), 1133, Congress preserved the concept that the plan documents are central to the claim, and it did not extensively regulate what plan documents may provide.

Instead, ERISA preserved the States' authority to enact "law[s] . . . regulat[ing] insurance," 29 U.S.C. § 1144(b)(2)(A), which can regulate the insurance products offered by the plan.[5] Sometimes that state regulation takes the form of legislation specifying what insurance benefits a plan must offer. *See, e.g.*, *Metro. Life*, 471 U.S. at 741-43. But the States'

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[5] Congress made an exception for plans that do not buy insurance but self-insure. *See* 29 U.S.C. § 1144(b)(2)(B); *see also FMC Corp. v. Holliday*, 498 U.S. 52, 61-65 (1990).

authority is broader than that. This Court has read the savings clause as authorizing *procedural* regulation as well, allowing the States to regulate the timeliness, denial, and administrative review of claims for such benefits. Thus, for instance, this Court upheld California's authority to regulate when an insurer may deny a claim as presented too late. *See Unum Life Ins. Co. of America v. Ward*, 526 U.S. 358, 375-77 (1999). And the Court likewise upheld Illinois's law significantly altering the procedure for administrative review of insurance benefit denials. *See Rush Prudential*, 536 U.S. at 365-75.

Less explicitly but no less clearly, the statute also permits state law to govern the timing of judicial review under ERISA even when that subject is not addressed by plan documents. Congress provided a statute of limitations for some claims under ERISA, *see* 29 U.S.C. § 1113, but not for others. As relevant here, the statute is silent about when a plaintiff must bring a claim like petitioner's for benefits due under the plan. Under the "longstanding" rule at the time of ERISA, state law would therefore presumptively set the limitations period. *See, e.g.*, *N. Star Steel Co. v. Thomas*, 515 U.S. 29, 33-35 (1995); *accord, e.g.*, *United Auto Workers v. Hoosier Cardinal Corp.*, 383 U.S. 696, 704-05 (1966).

None of these aspects of ERISA is consistent with petitioner's theory that Congress intended to impose an inflexible federal timing rule—and thus to preclude the well-established practice of linking the timing of suit to the presentation of proof of loss. To the contrary, Congress's silence on the subject suggests the opposite: as Congress provided neither the rule of decision nor the timing rules, it allowed

plans to regulate those matters by contract, subject to state insurance regulation.

Had Congress deemed the inclusion of timing provisions in ERISA plan documents at all troubling, it had many options at its disposal. It could have expressly prescribed when a suit for benefits due under the plan must be filed, as it did for other types of ERISA claims, or it could have prescribed an accrual rule. But Congress did neither of those things. And in the absence of something *in ERISA* to show that Congress sought to forbid plans from using the same well-established timing rule that they had used for decades, the "general principles" to which petitioner adverts cannot "override the applicable contract." *McCutchen*, 133 S. Ct. at 1551.

II. The Purposes Of The Timing Provision Are Consistent With ERISA's Statutory Scheme

Even if petitioner's appeal to broad policy objectives were relevant in answering a question governed so plainly by the plan documents, the plan's timing provision serves a purpose that is perfectly compatible with ERISA and its objectives. Petitioner's depiction of the provision as a rule that no one would want and that serves only to thwart judicial review (Br. 2-3) completely disregards the provision's actual aims and focuses instead on a wholly unrealistic hypothetical. The timing provision is not a means of impeding judicial review, and in fact *no one* has yet identified *a single person* whose attempt to seek judicial review was stymied by an overly protracted administrative claims process. Instead, basing deadlines on the proof-of-loss date serves important interests in finality and

financial stability that benefit both plans and their participants.

Like all limitations provisions, statutory and contractual alike, the timing provision sets a clear deadline for claimants to assert their right to sue, and it thus protects the plan against stale claims and the difficulties of proof they present. That objective is particularly important for ERISA-governed disability plans and their insurers. By setting a clear expiration date on potential benefits claims, the provision tells the insurer when it need no longer reserve funds against the potential liability that such claims represent. The ability to determine with near certainty when the books may be closed on a claim in turn benefits all stakeholders. First, reserves—including reserves based on stale claims—directly affect a plan or insurer's solvency and the amounts it must charge for premiums. Second, enforcing the accrual provision in both non-ERISA and ERISA-governed policies alike ensures that ERISA does not create a disincentive to offer these forms of insurance to employees as welfare benefits.

These salutary purposes are not at odds with ERISA's remedial scheme. To the contrary, the accrual provision accords with both the timetable on which plan administrators are legally required to process benefits claims and internal appeals and with judicial review after that process has run its course. Federal regulations strictly limit the extent to which plan administrators may delay the processing of claims or internal appeals, and impose serious consequences on administrators who might be tempted to try such gamesmanship. Moreover, the nature of federal court proceedings following the internal claims and appeals process—generally, the

review of an essentially closed paper record, not a full-blown evidentiary proceeding—means that claimants hardly need a period of years to prepare their case before seeking federal judicial review.

Combined, these realities more than allay the speculative concerns petitioner and her *amici* raise about opportunistic plan administrators running out the clock: claimants simply do not need the entire three-year limitations period (or even the majority of that period) to allow them to transition to federal court, and federal regulations assure that they will have ample time to prepare. Thus, while the timing provision was developed before ERISA, it fits hand in glove with ERISA's larger framework, evincing no reason why it should not be enforced along with the other provisions of the plan.

A. The Timing Provision Serves Sound Purposes Benefiting All Stakeholders In ERISA-Governed Disability Policies

All limitations provisions protect courts and defendants "from having to deal with cases in which the search for truth may be seriously impaired by the loss of evidence, whether by death or disappearance of witnesses, fading memories, disappearance of documents, or otherwise." *United States v. Kubrick*, 444 U.S. 111, 117 (1979). Those concerns are particularly powerful in the context of claims for disability benefits under ERISA. A claim for judicial review of a disability denial may be seeking retroactive benefits for a period of many years, during which time a claimant's disability status may have changed. Indeed, for *short-term* disability claims, the claimant may no longer contend that she *is* disabled, but only that she *was*. Both types of

claims may turn on a claimant's past physical condition and activities, which may be difficult or impossible to reconstruct—or to impeach—once years have passed. And while all evidence is supposed to be submitted during the initial claims process, courts conducting judicial review sometimes either consider new evidence themselves or remand for the plan administrator to do so. *See, e.g.*, *Rekstad v. U.S. Bancorp*, 451 F.3d 1114, 1119, 1121 (10th Cir. 2006) (remanding to plan administrator question of entitlement to benefits for period beginning more than ten years before the remand); *Buffonge v. Prudential Ins. Co. of Am.*, 426 F.3d 20, 24-25, 31-32 (1st Cir. 2005) (remanding to plan administrator and ordering it to allow new evidence on a claim that the insured became disabled nearly ten years before). Allowing judicial review to *begin* three years after a final claim denial—and many more years after the claimant contends she became disabled—only exacerbates the difficulty of litigating these years-old facts.

In addition, the timing provision establishes a firm cut-off date before which claims for denials of benefits must be brought, guaranteeing plans and insurers repose and finality as to any claims that are not brought within the specified time. The goals of repose and certainty are likewise typical of limitations provisions in general. *See Kubrick*, 444 U.S. at 117 (statutes of limitations "are statutes of repose"). But they are particularly important in the insurance context.

Perhaps more so than other types of defendants, insurers must be able to ascertain their potential claims exposure with reasonable certainty, so that they may properly estimate an appropriate "reserve,"

or expected loss. *See* 1 *Couch* § 2:29, at 2-125 to -27; *see also Md. Cas. Co. v. United States*, 251 U.S. 342, 350 (1920) (discussing the "special meaning" of the term "reserve" in the law of insurance).[6] Under most States' laws, insurers are required by statute "to maintain a legal reserve to meet liabilities on [their] policies" for the protection of their policyholders. 1 *Couch* § 2:29, at 2-125 to -27 (citing examples).[7] Proper estimation of reserves is fundamental in allowing insurers to "'budget' their finances," which has a direct effect on the balance sheet, in turn affecting the amount insurers must charge in premiums and other fees. *See* 17A *Couch* § 251:29, at 251-48; *see also Olin Corp. v. Ins. Co. of N. Am.*, 966 F.2d 718, 723 (2d Cir. 1992) ("[T]imely notice of occurrence assists insurers in estimating the amount of capital they need in reserve for future claims, and the amounts the must charge in premiums.").

By setting a fixed amount of time running from the date on which the loss occurred, such provisions

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[6] "Insurers use several methods or setting reserves," but all involve attempting to forecast the amount of money the insurer can expect to have to pay to resolve a claim in light of the probability of an adverse outcome. Timothy M. Sukel & Mike F. Pipkin, *Discovery and Admissibility of Loss Reserves*, 34 TORT & INS. L.J. 191, 194 (1998).

[7] Similarly, ERISA-governed plans must properly account for the contingent liabilities that unresolved claims for benefits due under the plan represent, including when appropriate by taking a charge against the plan's assets, as a function of the generally accepted accounting principles that plans must follow. *See* 29 U.S.C. § 1023(a)(3)(A); 29 C.F.R. § 2520.103-2(b)(3); Financial Accounting Standards Board, Accounting Standards Codification 450-20-25-2 (requiring charge against assets to be recognized for a loss contingency if it is probable to occur and if its amount can be reasonably estimated).

allow insurers to know with greater certainty which claims are too late and which may still be asserted. That knowledge allows insurers to close the books on stale claim files and relieves them of the need to reserve against those claims, or at least allows them to do so on a heavily discounted basis. *See, e.g.*, *Brandywine One Hundred Corp. v. Hartford Fire Ins. Co.*, 405 F. Supp. 147, 151 (D. Del. 1975) ("[T]he purpose of a policy limitation on suit is . . . so that files may be closed at a definite date, uncertainty as to the amount of an insurer's liability avoided, and stale claims cut off."); *Herman v. Valley Ins. Co.*, 928 P.2d 985, 990-91 (Or. Ct. App. 1996) ("Suit limitations provisions . . . enable an insurer to fix its present and future liabilities and to close stale claim files."); *see also* 14 *Couch* § 199:84, at 199-140 (suit limitation provisions "enable[] the insurer to fix its present and future liabilities and close stale claim files").

Under petitioner's rule, by contrast, the limitations period would run not from the date of the insured loss, but from the conclusion of administrative review—leaving plans and insurers unable to predict the limitations period until several contingent events have occurred. Absent a concrete limitations period, an insurer "could not accurately forecast its future liabilities, set aside proper reserves, or close even ancient claim files." *Herman*, 928 P.2d at 991. An insurer faced with an uncertain limitations period will therefore require larger reserves—enough to cover claims that would otherwise be deemed stale. *See id.* That in turn may

increase costs to plan participants.[8] Moreover, a special rule that would disallow the timing provision in ERISA-governed policies—even though it is uncontroversial in non-ERISA insurance products—might also discourage insurers from offering such policies in the first place. That outcome would undermine, rather than promote, Congress's goal of encouraging employers to offer employee benefit plans. *See Conkright*, 130 S. Ct. at 1649. Avoiding that counterproductive result, as the timing provision does, benefits employees, employers, and insurers alike.

B. The Timing Provision Does Not Forestall Judicial Review

Petitioner and her *amici* nevertheless argue that the timing provision is at odds with ERISA's remedial scheme because, they claim, it *might* enable plan administrators to procrastinate during the mandatory internal claims and appeals process for the entire limitations period (here, three years), effectively shutting the federal courthouse door to worthy claimants. *E.g.*, Pet. Br. 2-3; AARP Br. 15. But no one has yet sighted that particular yeti. So far as petitioner can demonstrate and research can reveal, in the nearly forty years that ERISA has coexisted with timing rules tied to the date of loss, no claim for benefits due under the plan has *ever* become time-barred because of delays attributable to

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[8] *See, e.g.*, Ellen Wertheimer, *Calling It a Leg Doesn't Make It a Leg: Doctors, Lawyers, and Tort Reform*, 13 ROGER WILLIAMS U. L. REV. 154, 181 (2008) (discussing relationship between increased reserve requirements and insurance premiums in malpractice context).

exhaustion. Nor is such a case likely to occur in the future.

1. Federal law limits the time that exhaustion may consume

Contrary to petitioner's contentions, the internal claims and appeals process is far from "open-ended." Pet. Br. 8. To the contrary, the Labor Department's regulations now strictly limit both the amount of time that a plan's internal claims and appeals process can take as well as the number of levels of internal review a plan can require claimants to undergo. *See* Resp. Br. 40-41; 29 C.F.R. § 2560.503-1(c)(2), (d), (f)(3), (h)(3), (h)(4), (i)(3).

While extensions of some of these deadlines are allowed, those extensions are also limited in both number and availability. For example, while the regulations allow the plan to request additional information from the claimant and toll the period for making its decision while such requests are outstanding, the plan also is required to "specifically explain . . . the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues." *Id.* § 2560.503-1(f)(3), (f)(4). And while claimants are guaranteed at least forty-five days to respond to requests for information, plan administrators will still, as a practical matter, set a deadline by the claimant must respond. *See, e.g.*, *MacLennan v. Provident Life & Accident Ins. Co.*, 676 F. Supp. 2d 57, 60 (D. Conn. 2009) (noting that plaintiff was required by the plan to submit additional information or to request an extension of time to do so, by a date certain). Similarly, while the plan administrator may extend the deadline for its initial benefits determination by

a total of up to 60 days, but only if "necessary due to matters beyond the control of the plan." 29 C.F.R. § 2560.503-1(f)(3). The Department interprets that proviso not to include, for example, "delays caused by cyclical or seasonal fluctuations in claims volume," because they are not "matters beyond the control of the plan." 65 Fed. Reg. 70,246, 70,250 (Nov. 21, 2000).

A plan disregards those time limits at its peril. If a plan fails to meet the regulatory deadlines, the participant can go straight to court—and potentially have an argument to defeat the plan's claim to interpretive discretion and the deferential standard of review. *See* Resp. Br. 41 & n.18; 29 C.F.R. § 2560.503-1(*l*). The same consequences follow when plans structure or administer their internal process "in a way[] that unduly inhibits or hampers the initiation or processing of claims for benefits." *Id.* § 2560.503-1(b)(3), (*l*).

2. Following exhaustion, a plaintiff does not need three years to file suit

It is true that *some* of the three-year limitations period will overlap with the time spent exhausting plan remedies. But that overlap is not problematic on its face; as respondents demonstrate (Br. 34), three years from the proof-of-loss date actually gave petitioner a *longer* time than she might have been allowed under her preferred rule. Petitioner cannot show that the timing provision conflicts with ERISA without showing that exhaustion will consume *so much* of the three-year period as to impede meaningful judicial review.

A benefits-due-under-the-plan claim under ERISA requires far less preparation than do more

garden-variety lawsuits. With most claims, the plaintiff must undertake some pre-suit investigation to ensure both that she can plead "sufficient factual matter . . . to 'state a claim for relief that is plausible on its face,'" *Ashcroft v. Iqbal*, 556 U.S. 662, 697 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)), and also that she satisfies Fed. R. Civ. P. 11(b)'s duty of reasonable inquiry. It is in part for that reason that statutes of limitations typically allow the plaintiff a period of years to bring suit: so that she has sufficient time to undertake such investigation. *See Kubrick*, 444 U.S. at 122-24; *see also Gabelli v. SEC*, 133 S. Ct. 1216, 1222 (2013) ("Most of us do not live in a state of constant investigation," and "absent any reason to think we have been injured, we do not typically spend our days looking for evidence").

By contrast, a plaintiff like petitioner cannot credibly claim that she needed three years from the end of internal claims review to investigate her federal claim for benefits. Much of the development of a claim like petitioner's takes place *during* the internal claims review and appeal process. The claimant has the right to present a substantial record to the plan administrator in support of her claim, including documentary and expert evidence, and she also may (as is not uncommon) be represented by counsel or some other authorized representative. *See* 29 C.F.R. § 2560.503-1(b), (d), (h)(2)(ii)-(iv), (h)(3)(i)-(v), (h)(4); *see also, e.g.*, *White v. Sun Life Assurance Co. of Can.*, 488 F.3d 240, 256 (4th Cir. 2007) (Wilkins, C.J., dissenting) (noting claimant was represented by counsel during internal appeals process); *Doe v. Blue Cross & Blue Shield*

United of Wis., 112 F.3d 869, 875 (7th Cir. 1997) (same); Pet. App. 8 (same).

Once the claimant has exhausted the plan's internal claims process, there generally is little if any further factual investigation to be done for purposes of initiating the judicial proceeding, as the district court performs what is usually akin to judicial review of final administrative action on a paper record. *See Doe*, 112 F.3d at 875. Indeed, the federal court's review usually is limited to the record developed during the plan's claims and appeals process, and claimants are often *prohibited* from submitting additional evidence to support their claims. *See, e.g.*, *Muller v. First Unum Life Ins. Co.*, 341 F.3d 119, 125 (2d Cir. 2003) (while district court has discretion to consider non-record evidence, "the presumption is that judicial review is limited to the record in front of the claims administrator" (citation and internal quotation marks omitted); *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1094 (9th Cir. 1999) (same); *Perry v. Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990) (new evidence may not be considered by district courts even on *de novo* review).

In similar proceedings seeking judicial review of another tribunal's decision on a closed paper record, the time to seek review is ordinarily measured not in years but in months (and sometimes only in days). *See Doe*, 112 F.3d at 875; Fed. R App. P. 4(a)(1). For example, this Court has recognized that, depending on the nature of the claim and the defendants, 90 or 180 days is sufficient to allow a worker to seek judicial review of an arbitration decision under the Labor Management Relations Act, a statutory scheme which (like ERISA) generally requires pre-suit exhaustion. *See, e.g.*, *DelCostello v. Int'l Bhd. of*

Teamsters, 462 U.S. 151, 163-64, 169-72 (1983); *United Parcel Service, Inc. v. Mitchell*, 451 U.S. 56, 62-64 (1981). Congress has made similar judgments when setting other periods of time to seek limited federal judicial review of an agency's or arbitrator's decision. *See, e.g.*, 9 U.S.C. § 12 (90 days allowed for actions seeking to vacate or correct arbitration awards); 42 U.S.C. § 2000e-5(f)(1) (Title VII plaintiffs have 90 days to file suit after administrative review of discrimination charges ends).

Petitioner had more than a year to seek federal judicial review of the denial of her claim. Pet. App. 7-9. But even if some claimants have less time—a period of months—that result is hardly so troubling as to override an otherwise-applicable plan term. To the contrary: because claimants are assured a full and fair opportunity to present their case to the plan administrator, and because they also will generally be barred in federal court from relying on additional new evidence, affording them *three years* to file suit would be far more troubling from the standpoint of repose, *see supra* pp. 19-23. It does not take three years to draft a pleading that may be styled as a complaint, but is in essence a detailed notice of appeal, seeking on-the-record review that is "classically appellate in character." *Cf. City of Chicago v. Int'l Coll. of Surgeons*, 522 U.S. 156, 165 (1997) (Ginsburg, J., dissenting).

3. Purely hypothetical exhaustion delays are not a basis for disregarding an ERISA plan's timing provision

Ultimately, petitioner cannot contend that *she* lacked adequate time to file suit. She therefore contends that her rule is necessary to ensure that

everyone will have adequate time to file suit. But in light of the claims regulations and the modest amount of time necessary to assemble an ERISA claim once exhaustion is complete, she fails to show that timing provisions based on the date of loss pose any genuine danger.

None of the cases on which petitioner principally relies (Pet. 19-27) presents the problem she fears. For example, in the sole appellate decision in which this concern motivated the court to reject a timing provision based on the date of loss, the claimant had ample time remaining on the clock—more than 28 months—once exhaustion was finished. *See White*, 488 F.3d at 256 (Wilkins, C.J., dissenting).

Indeed, the limited number of reported decisions on this issue strongly suggests that there is no real danger of litigants' becoming time-barred during the exhaustion process. The last five years of federal district court cases contain only 48 decisions that address the timeliness of the plaintiff's claim under the applicable limitations period.[9] Of those, 20 do not discuss how long it took for the plaintiff to exhaust remedies because it was unimportant to the court's analysis. Of the remaining 28, exhaustion took on average about 16 months. The median time to exhaust was 15 months.[10]

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[9] A Westlaw search in the DCT database for "ERISA & disability & limitation & 'proof of loss,'" narrowed to include one of the terms "time-barred," untimely, late, "statute of limitation," "limitations period," or "contractual limitations," produces 105 results during that five-year period. Of these, only 48 actually involve a relevant statute of limitations issue.

[10] In none of these cases did exhaustion take more than three years. In only one outlier case, involving extensive delay by the

Without evidence, petitioner's *amicus* United Policyholders (UP) turns to hypotheticals, but even the nightmare scenario it posits does not prove its point—much less justify its legal conclusion. UP postulates a hypothetical claimant whose plan took approximately 21 months to deny her initial benefits claim and first-level appeal as a result of various extensions and exclusions assumed to be permissible under the regulations, noting that under many plans, another level of appeal would be required to exhaust remedies. UP Br. 5-9. UP then supposes—with no basis in the regulations or in evidence—that a second-level appeal might take "an additional year." UP Br. 9. But *even under those extreme and hypothetical facts*, the claimant would still have fully three months (of the 36-month contractual limitations period) left to file in federal court.

Ultimately, the most that UP can suggest is that in a case in which every deadline is stretched to the maximum, exhaustion might consume "nearly three years," but still leave the claimant with months to seek federal judicial review. As shown above, in this context that period of months is adequate. And even if it were not, concerns about the adequacy of the time remaining in such an extraordinary case would not be a reason to give *every* claimant in *every* case the option of waiting several years following

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claimant, did exhaustion come within a month of that length of time. The claimant (represented by counsel) took almost ten months to file his first-level appeal and more than a year to file his second-level appeal; the plan considered his claim for less than 14 months, all told, but the claimant's delays caused exhaustion to take approximately 35 months total. *See Gassiott v. Prudential Ins. Co.*, No. 08 Civ. 7358, 2009 WL 3188428, at *1-2 (S.D.N.Y Oct. 6, 2009).

exhaustion before filing suit. *See Doe*, 112 F.3d at 875.

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In the context of accrual and tolling principles, this Court "should not craft rules for the needle rather than the haystack." *Wallace v. Kato*, 549 U.S. 384 (2007) (Stevens, J., concurring in the judgment). Petitioner cannot show that this haystack has ever contained a needle (or will ever contain one). The hypothetical scenario in which plan administrators cause claimants to become time-barred is precisely that—a hypothetical. A merely imaginary problem is no reason to overturn a settled insurance principle, particularly without any basis in the statute's text, structure, or history.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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