No. 07-___

In The

Supreme Court of the United States

SUN LIFE ASSURANCE COMPANY OF CANADA,

Petitioner,

v.

MARGARET T. WHITE,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the Fourth Circuit erred in holding, contrary to five other circuits, that an unambiguous limitations period contained in an ERISA-governed disability insurance policy was *per se* unenforceable solely because the policy required the limitations period to begin when proof of claim was due under the policy rather than when the benefit claim was denied, where the limitations period allowed Respondent more than 28 months to file suit after her benefit claim was denied, and where the policy language was mandated by state insurance laws in North Carolina and forty-eight other states.

PARTIES TO THE PROCEEDING

Margaret T. White was the plaintiff in the district court and the appellee in the Fourth Circuit. Sun Life Assurance Company of Canada ("Sun Life") was the defendant in the district court and the appellant in the Fourth Circuit. Other parties who were originally named as additional defendants in the district court are no longer parties to this proceeding, having been dismissed by the district court.

CORPORATE DISCLOSURE STATEMENT

Sun Life Assurance Company of Canada is a wholly owned subsidiary of Sun Life Financial Inc., a publicly traded company. No publicly traded entity owns 10% or more of the stock of Sun Life Financial Inc.

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Life, health, and disability benefit plans governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, *et seq.* ("ERISA") are frequently funded by insurance. *See, e.g.,* 29 U.S.C. §1002(1) (defining an employee welfare benefit plan as being funded "through the purchase of insurance or otherwise"). Insurance laws in forty-nine states require life, health, and disability insurance policies to include, among other provisions, a limitations period that accrues at the time proof of claim is due under the policy. There is nothing in ERISA that forbids a proof of claim accrual clause. In fact, ERISA does not even specify a limitations period applicable to suits for denied benefits, leaving these and other plan provisions to the discretion of plan drafters. *See generally Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 833 (2003) ("employers have large leeway to design . . . plans as they see fit").

Prior to 2007, published decisions by the Fifth, Seventh, and Eighth Circuits, and unpublished decisions by the Sixth and Tenth Circuits, enforced insurance policy proof of claim accrual clauses in ERISA benefit suits. Only the Ninth Circuit refused to do so. Now the Fourth Circuit has joined the minority view. Combined with a Third Circuit decision issued earlier in 2007, there are now three circuits that have virtually erased universal, mandatory, and unambiguous language from hundreds of policies that fund ERISA plans across the United States, not because of any prohibition in the ERISA statute, but based upon perceived policies of ERISA. Even worse, the three circuits that rejected proof of claim accrual provisions adopted different "default" accrual rules, leaving ERISA plans and their insurers subject to varying rules that are not only

inconsistent with the unambiguous terms of the plans, but are also inconsistent with each other.

The matter is ripe for review. First, with two circuits joining the minority position, there is now a broad split in the circuits. Second, national ERISA plans that are supposed to be subject to uniform federal regulation, are now subject to inconsistent application of identical plan terms, depending upon where lawsuits are filed. Third, the reasoning of the Fourth Circuit and similar decisions causes other ERISA plan terms to be subject to challenge based on contentions that the plan terms are somehow in "tension" with perceived policies of ERISA, even when the terms are clear and unambiguous and there is no statutory provision governing the terms. Finally, this Court's decision in *Order of United Commercial Travelers v. Wolfe,* 331 U.S. 586 (1947), which gave effect to parties' freedom of contract by holding that a contractual limitations period is enforceable where it provides a reasonable time to file suit, is rejected, apparently on the ground that ERISA plan drafters do not share the same contractual freedom. In the end, ERISA plans and their insurers are caught in the middle – on the one hand, state insurance laws forbid insurers from issuing insurance policies that exclude state mandated language and, on the other hand, insurers are *per se* prohibited from enforcing the very same language. The question of when a contractual limitations period begins has broad application to ERISA life, health, and disability plans, their administrators and insurers, as well as non-ERISA entities such as state insurance regulators.

The facts of this case provide a prime vehicle for review of the legal issue. It is undisputed that the policy clause was unambiguous. It is undisputed that, as applied to the facts in this case, the limitations period allowed

Respondent, who was represented by counsel, more than reasonable time (over 28 months) to file suit after her benefit claim was denied. It would be difficult to have a more appropriate factual scenario for resolution of the question presented. Petitioner respectfully requests that the Court grant the writ and overturn the Fourth Circuit decision.

OPINIONS AND ORDERS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit, filed on April 26, 2007, is reported at 488 F.3d 240, and is reproduced at Appendix ("App.") 1-47. The Fourth Circuit denied a petition for rehearing *en banc* on June 11, 2007, which decision is unreported and is reproduced at App. 77-78. The decisions of the trial court are reproduced at App. 48-57 (Memorandum and Order dated August 11, 2005); App. 58-73 (Memorandum and Recommendation dated January 7, 2005); and App. 74-76 (Order Clarifying and Amending Memorandum and Order dated September 9, 2005).

JURISDICTION

Respondent filed suit in state court as a result of Sun Life's decision to deny her claim for disability benefits under an ERISA plan. Petitioner and other defendants jointly removed the case to federal court based on ERISA, 29 U.S.C. §1132(e)(1). Petitioner appealed to the Fourth Circuit following an adverse judgment in the district court, pursuant to 28 U.S.C. §1291. The Fourth Circuit affirmed the district court on April 26, 2007. Petitioner sought

rehearing *en banc,* which was denied on June 11, 2007. This Petition is being filed within the ninety-day period following entry of that order pursuant to Sup.Ct.R. 13.1 and 13.3. Petitioner invokes the jurisdiction of this Court under 28 U.S.C. §1254(1).

STATUTES INVOLVED

This case involves section 502(a)(1)(B) of ERISA, 29 U.S.C. §1132(a)(1)(B) and North Carolina General Statutes §58-51-15. The text of these statutes is set out in App. 79 and 80-97, respectively.

STATEMENT OF THE CASE

Factual Background. Respondent was a participant in an ERISA-governed disability plan sponsored by her employer. Benefits were funded by a group disability insurance policy ("Policy") issued by Petitioner. Like most policies of its kind, the Policy included a limitations period as follows:

> No legal action may start . . . more than 3 years after the time Proof of Claim is required.

The Policy was issued in North Carolina in a form approved by the North Carolina Department of Insurance. The limitations period language, including the accrual clause, was mandated for inclusion in the Policy by North Carolina General Statutes §58-51-15:

> (a) Required Provisions – Except as provided in subsection (c) of this section each such policy delivered or issued for delivery to any person

> in this State shall contain the provisions specified in this subsection in the substance of the words that appear in this section. . . .
>
> (11) A provision in the substance of the following language:
>
> LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 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.*

App. 80, 87-88 (emphasis added).

The Policy required that Proof of Claim be submitted "no later than 90 days after the end of the Elimination Period." The "Elimination Period" was 90 days and was defined as "a period of continuous days of Total or Partial Disability for which no LTD [Long Term Disability] Benefit is payable." The Elimination Period "begins on the first day of Total or Partial Disability."

Respondent alleged in her Complaint that her "first day of Total Disability" under the Policy was February 11, 2000. Respondent's Elimination Period expired 90 days later, on May 11, 2000. Her Proof of Claim was due 90 days thereafter, or August 9, 2000. The Policy limitations period expired three years later, on August 9, 2003.

Respondent filed her claim for disability benefits with Petitioner. Following review and an administrative appeal, Petitioner's final notice of denial was sent to Respondent's counsel on March 28, 2001. Respondent had over 28

months – until August 9, 2003 – to file a lawsuit. In May 2002, more than a year after the final claim denial, Respondent's counsel attempted to submit additional information. On May 29, 2002, Petitioner advised in writing that administrative remedies had been previously exhausted and that there would be no further review of the claim. Respondent still had over 14 months to file suit. Respondent did not file suit until March 26, 2004, more than seven months after the Policy limitations period expired.

Proceedings Below. After Respondent's Complaint was removed to federal court under ERISA, Petitioner filed a motion to dismiss on the following grounds: (1) Respondent's state law claims were preempted by ERISA; and (2) Respondent's ERISA claim for benefits was barred by the limitations period in the Policy.

On January 7, 2005, United States Magistrate Judge Dennis Howell of the United States District Court for the Western District of North Carolina entered a Memorandum and Recommendation, converting Petitioner's motion to dismiss into a motion for judgment on the pleadings and granting the motion, ruling that (1) Respondent's state law claims were preempted by ERISA; and (2) Respondent's ERISA claim for benefits was untimely because she did not file this action within the limitations period mandated by the Plan.

Respondent filed objections to the Magistrate's Memorandum and Recommendation. By Order dated August 11, 2005, United States District Judge Lacy H. Thornburg rejected the recommendation of Magistrate Howell regarding the limitations period issue. The district court ruled

that the accrual clause in the Policy was not enforceable as a matter of law.[1]

On September 12, 2005, the parties filed cross-motions for summary judgment on Respondent's claim for benefits under ERISA, 29 U.S.C. §1132(a)(1)(B).[2] On January 31, 2006, the district court awarded Respondent past due benefits, attorney fees, and costs. Petitioner appealed. On April 26, 2007, in a 2-1 decision, the Fourth Circuit affirmed the district court. Addressing the limitations period issue, the majority conceded that the ERISA statute contains no limitations period applicable to benefit suits and agreed that ERISA plans, like other contracts, may incorporate a limitations period if the period is reasonable. The majority also agreed that the limitations clause in the Policy was unambiguous and that the time remaining for Respondent to file suit after her claim was denied (more than 28 months) was reasonable. However, the majority held that unambiguous ERISA plan language requiring the contractual limitations period to begin on the date a claimant's proof of claim was due was *per se* unenforceable. The majority concluded that parties to an ERISA plan may not alter the federal default rule that a limitations period begins when the claim is denied. The majority stated that the plan's limitations period provided an unacceptable level of uncertainty because starting a limitations period before a claim is denied would allow

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[1] On September 9, 2005, the district court clarified its previous Order by expressly adopting Magistrate Howell's recommendation that Respondent's state law claims were preempted by ERISA.

[2] ERISA, 29 U.S.C. §1132(a)(1)(B) provides in part that an employee benefit plan participant may sue to recover "benefits due to him under the terms of his plan."

unscrupulous ERISA claim administrators to delay claim decisions in order to compress the limitations period and because courts would be required to determine in each case whether the remaining period was reasonable.

A lengthy dissent concluded that the limitations period was "eminently reasonable" because it provided Respondent more than sufficient time to file her lawsuit, that the Policy language was "the very one that North Carolina and the vast majority of other states require be included in insurance policies like the one at issue here," and that no controlling law prohibits adoption of the limitations period specified in the Policy. He observed that absent a law preventing a limitations period shorter than the default period, this Court's precedent requires that the contractual periods be enforced so long as they are reasonable. *See Order of United Commercial Travelers v. Wolfe,* 331 U.S. 586, 608 (1947). He observed that tying the limitations period to the date that proof of claim was due has the perfectly rational purpose of ensuring that no suit is too remote in time from the events giving rise to the claim.

The dissent also rejected the majority's conclusion that federal common law can override the unambiguous terms of an ERISA plan. He explained that the three-year period was well designed to leave a claimant with ample time to decide whether to file suit. ERISA claim regulations allow a claim administrator no more than 195 days to decide a claim, including any administrative appeal, thereby eliminating "any significant possibility that a devious plan administrator could believe he could run out the three-year clock on a claimant before the claimant could sue." 488 F.3d at 261. The dissent also stated that, regardless of whether the majority might identify policy

reasons why the default period would be preferable, it is for the plan drafter to determine plan terms, not the courts.

The dissent concluded that it was the majority's refusal to enforce the clear plan language that created uncertainty in the administration of ERISA plans. Under the terms of the plan, from the time the Plaintiff filed her administrative claim, she was on notice that the date by which she was required to file a civil action was August 9, 2003. The dissent concluded that "it is the majority that pulls the rug out from under the parties at this late stage of the litigation by refusing to enforce the plan as written." *Id.* at 262. The dissent also expressed concern that the majority's reliance on federal common law to nullify unambiguous ERISA plan terms "will also leave future claimants and plan administrators under a variety of plans wondering which plan provisions this court will refuse to apply next." *Id.*

REASONS FOR GRANTING THE WRIT

I. THE FOURTH CIRCUIT DECISION WARRANTS REVIEW BECAUSE IT BROADENS A CIRCUIT SPLIT OVER WHETHER OR NOT TO ENFORCE ERISA-GOVERNED INSURANCE POLICY PROVISIONS THAT REQUIRE A LIMITATIONS PERIOD TO BEGIN AT THE TIME PROOF OF CLAIM IS DUE.

Limitations periods are an integral part of any commercial transaction. Likewise with employee benefit plans governed by ERISA. While many limitations periods are statutory, Congress did not include a specific limitations

period applicable to ERISA suits for denied benefits under 29 U.S.C. §1132(a)(1)(B). As a result, lower courts have resorted to the "most analogous" state statutory period except where the ERISA plan itself contains a limitations period, in which case courts have enforced the period where reasonable, in accordance with *Order of United Commercial Travelers v. Wolfe,* 331 U.S. 586, 608 (1947) (holding that it is "well established" that contractual limitations periods are binding between the contracting parties where the period is reasonable). Application of contractual limitations periods is consistent with the principle that where ERISA does not specifically address an issue, "employers have large leeway to design . . . plans as they see fit." *Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 833 (2003).

Where ERISA plans are funded by insurance policies, the policies are required to comply with state insurance laws. *See* 29 U.S.C. §1144(b)(2)(A) (exempting from pre-emption state laws that regulate insurance). For many years, forty-nine states (as well as the District of Columbia and at least two territories) have uniformly required group life, health, and disability insurance policies to include limitations periods that accrue at the time proof of claim is due. App. 98 (chart showing state statutory provisions). In North Carolina, failure to obtain approval of insurance policy forms may constitute an unfair trade practice. *See, e.g., Richardson v. Bank of America,* 643 S.E.2d 410, 425-26 (N.C. App. 2007). Over the past fifteen years, eight circuit courts have weighed in on the question of whether an ERISA-governed insurance policy can require the policy's limitations period to begin at the time the participant's proof of claim is due. The Fifth, Seventh, and Eighth Circuits have held that such a requirement is

enforceable so long as there is reasonable time remaining after the claim process is completed for a participant to file suit. Two unpublished decisions from the Sixth and Tenth Circuits hold likewise. In contrast, the Third, Fourth, and Ninth Circuits prohibit proof of claim accrual provisions in ERISA actions as a matter of law and regardless of whether or not they allow a reasonable time to file suit.

The circuit split is mature: the varied circuit court decisions have been issued over a fifteen-year period. The circuit split is also getting worse, not better. Until 2007, only one circuit – the Ninth – refused to enforce proof of claim accrual provisions, whereas five circuits applied the provisions in ERISA benefit suits. The decision below and a recent Third Circuit decision irrevocably broaden the split. Regardless of how the remaining circuits rule on the issue, the split will continue and is problematic.

A. The Fourth Circuit Decision Conflicts with Published Decisions in the Fifth, Seventh, and Eighth Circuits and with Unpublished Decisions in the Sixth and Tenth Circuits.

Published and unpublished decisions in the Fifth, Sixth, Seventh, Eighth, and Tenth Circuits, have all enforced accrual dates that run from events other than the denial of benefits. *See Harris Methodist Fort Worth v. Sales Support Services Inc. Employee Health Care Plan*, 426 F.3d 330, 337-38 (5th Cir. 2005) (enforcing three-year limitations period that began to run from date proof of loss was due); *Doe v. Blue Cross & Blue Shield United of Wisconsin*, 112 F.3d 869, 875 (7th Cir. 1997) (enforcing thirty-nine month limitations period that began to run from the date of the services for which benefits were sought); *Blaske v. Unum*

Life Insurance Company of America, 131 F.3d 763, 764 (8th Cir. 1997), *cert. denied*, 525 U.S. 812 (1998) (enforcing policy limitations provision that began the period at the time that proof of claim was required); *Clark v. NBD Bank, N.A.*, 3 Fed. Appx. 500 (6th Cir. 2001) (enforcing plan limitations period providing that "no action . . . shall be brought after the expiration of three years after the time written proof of loss is required to be furnished"); *Moore v. Berg Enters.*, 1999 U.S. App. LEXIS 30481 (10th Cir. 1999) (enforcing three-year statute of limitations running from the date proof of loss was required).

The Fifth Circuit enforced an ERISA plan's limitations period that required an action to recover benefits to be filed within "three (3) years from the time written proof of loss is required to be given." *Id.* The Fifth Circuit acknowledged that *generally* under ERISA, a cause of action accrues after a claim for benefits has been formally denied. However, in applying a contractual limitations period that began to run from the date proof of loss was due, the Fifth Circuit reasoned: "Because ERISA provides no specific limitations period, we apply state law principles of limitation . . . *Where a plan designates a reasonable shorter time period, however, that lesser limitations schedule governs.*" *Harris*, 426 F.3d at 337 (emphasis added). Although the Fifth Circuit ultimately found the action to be timely, it was only after a lengthy discussion of how the term "loss" should be interpreted so that the court could determine the accrual date as specified by the plan.

Similarly, in the Seventh Circuit decision in *Doe v. Blue Cross & Blue Shield United of Wisconsin, supra*, the plan required that any legal action be commenced within 39 months after the date of the services for which benefits were sought (a health plan was at issue in *Doe*). Unlike

the present case, where the claim review process was uneventful, the plaintiff and the plan in *Doe* were involved in a protracted claim process, which spanned nearly a year and a half of the limitations period. Even so, when the final decision was announced, the plaintiff still had another 17 months to bring suit, but he waited another year and a half. *Doe*, 112 F.3d at 872-73, 875. The Seventh Circuit had no difficulty concluding that the limitations period and accrual date in the employee benefit plan were reasonable "in general and in [that] case." *Id.* at 875. The court noted that, like the present case, the employee had been represented by counsel throughout the administrative appeal process and that the plan provided the plaintiff substantially more than the 30 to 60 days a litigant would ordinarily have to appeal an administrative decision. *Id.* Noting that the plan participant was required to exhaust administrative remedies before filing suit under ERISA, the Seventh Circuit expressed concern that if the internal appeals process took longer than the contractual limitations period, the plaintiff could be barred from suing even though the plan forbade him to sue earlier. *Id.* at 873. However, the court held that the applicable deadline was enforceable in that case because the plaintiff had more than a year after the claim was denied in which to commence suit, a period the court deemed reasonable. *Id.*

In *Blaske v. Unum, supra,* a disability insurance policy provided that any legal action "cannot be maintained after three years from the date that proof of claim is required." 131 F.3d at 763. The plaintiff filed suit after her disability claim was denied. The disability insurer moved for summary judgment on the ground that suit was not filed within the time period specified in the policy.

Finding that the policy period was more liberal than the otherwise applicable state statutory limitations period, the Eighth Circuit applied the policy period and affirmed summary judgment in favor of the insurer.

In *Clark v. NBD Bank, supra*, the Sixth Circuit enforced a plan's limitations provision providing that no action could be brought after the expiration of three years from the time written proof of loss was required. Like *Doe,* the Sixth Circuit relied on *Order of United Commercial Travelers v. Wolfe, supra*, and held that contractual limitations periods are enforceable so long as they are reasonable:

> Courts have adhered to the rule that, 'in the absence of a controlling statute to the contrary, a provision in a contract may validly limit, between the parties, the time for bringing an action on such contract to a period less than prescribed in the general statute of limitations, provided that the shorter period itself shall be reasonable.' . . . 'Congress' silence on a limitation period . . . shows its willingness to accept reasonable limitations periods rather than a strong policy in favor of some particular limitations period.' . . . Many courts have specifically applied this general rule of law to claims brought under ERISA.

Clark, 3 Fed. Appx. 500, 503-04 (6th Cir. 2001).

Finally, in *Moore v. Berg Enters., Inc., supra*, the Tenth Circuit enforced an ERISA plan's limitations period that precluded actions to recover benefits filed more than three years after the time proof of claim was required. The Tenth Circuit held that the contractual limitations period and accrual date were reasonable and enforceable:

> ERISA contains no statute of limitations which governs claims under section 1132(a)(1)(B) or section 1132(c). Courts therefore look to the "most analogous" state statute of limitations . . . or if the plan itself contains a limitations period, to the plan if the contractual limitations period is reasonable.

Moore, 1999 U.S. App. LEXIS 30481 at *6-7.

B. The Fourth Circuit Decision is Consistent with Decisions in the Third and Ninth Circuits, Irrevocably Broadening a Long-standing Split in the Circuits.

While the clear weight of authority among the circuits had been to enforce ERISA-governed insurance policy accrual dates that begin to run when proof of claim is due, the Fourth Circuit relied on an older Ninth Circuit case and a recent Third Circuit decision to support its contrary decision. *Price v. Provident Life & Accident Ins. Co.*, 2 F.3d 986 (9th Cir. 1993); *Miller v. Fortis Benefits Ins. Co.*, 475 F.3d 516, 520-21 (3d Cir. 2007).

In *Price v. Provident,* the plaintiff submitted several claims to her medical insurer. The claims were incurred in 1983, but the plaintiff did not file suit until 1991. The health insurance policy required that suits be filed "within three years of the date on which the proof of loss was required to be furnished." The plaintiff argued that, despite the clear language of the policy, the period for filing suit should not begin until he was notified that his claims were denied. Relying on reasoning similar to the Fourth Circuit in this case, the Ninth Circuit held that the policy accrual provision was *per se* unenforceable and that the limitations period would not begin until the plaintiff

had reason to know about the denial. 2 F.3d at 989. The Ninth Circuit remanded the matter to the district court to determine the date on which the plaintiff became aware of his claim.

In *Miller v. Fortis, supra,* the Third Circuit also refused to enforce language in an ERISA-governed policy that stated that an action must be brought no later than "6 years after the time required for submitting the proof has expired." 475 F.3d at 518. The Third Circuit declined to adopt a blanket rule that ERISA limitations periods begin at the time a claim for benefits is denied, as was done by the Fourth Circuit in this case. Instead, the Third Circuit adopted yet another formula, *i.e.*, that a limitations period in an ERISA benefit suit begins to run when there is a "clear repudiation" of a benefit claim, even if that occurs *before* the claim is formally denied. *Id.* at 522-23.

Ironically, the approaches taken by the three circuits that have prohibited proof of claim accrual provisions are not only inconsistent with decisions in five other circuits and with express plan terms, but are also inconsistent with one another. The Third, Fourth, and Ninth Circuits have rejected a uniform insurance policy provision that has existed for years in favor of a supposedly more uniform "default rule" and yet these circuits do not even agree on the default rule. The Fourth Circuit "default" rule is that a limitations period accrues when the claim is denied, which the majority characterized as "the familiar federal accrual standard." *White,* 488 F.3d at 253. The Third Circuit default rule is based on "clear repudiation" of a claim, which it acknowledged may occur before the claim is formally denied. *Miller,* 475 F.3d at 521. The Ninth Circuit applies an accrual rule based on when the claimant has reason to

know about the denial, which may or may not overlap with the "clear repudiation" rule. *Price,* 2 F.3d at 988. Not only do these standards require factual inquiries in each case, something the Fourth Circuit purported to avoid by rejecting proof of claim accrual provisions, but the Third Circuit recognized that the circuits are not in harmony regarding a supposed default accrual rule, stating "we recognize that our application of the clear repudiation rule diverges from that of other courts confronting the same issue." *Id.* at 523. In summary, the three circuits that reject a virtually universal proof of claim accrual provision, in part on the ground that it creates inconsistency, have themselves created even more inconsistency by adopting varying "default" accrual rules.

II. THE FOURTH CIRCUIT DECISION CONFLICTS WITH *ORDER OF UNITED COMMERCIAL TRAVELERS V. WOLFE* WHICH HOLDS THAT CONTRACTUAL LIMITATIONS PERIODS ARE ENFORCEABLE IF THEY ALLOW A REASONABLE TIME TO FILE SUIT.

In establishing default rules for ERISA benefit suits, courts have looked to state law regarding the length of limitations periods, *see Wilson v. Garcia,* 471 U.S. 261, 266-67 (1985), while holding that federal law governs the date when the limitations period commences, *see Rawlings v. Ray*, 312 U.S. 96, 98 (1941). Notwithstanding the existence of these default rules,

> it is well established that, in the absence of a controlling statute to the contrary, a provision in a contract may validly limit, between the parties, the time for bringing an action on such contract to a period less than that prescribed in the general

> statute of limitations, provided that the shorter period shall be a reasonable period.

Wolfe, 331 U.S. at 608. As the Fourth Circuit dissent concluded, the *Wolfe* rule clearly applies to an ERISA plan which "is nothing more than a contract, in which parties as a general rule are free to include whatever limitations they desire." 488 F.3d at 258; *Northlake Reg'l Med. Ctr. v. Waffle House Sys. Employee Benefit Plan*, 160 F.3d 1301, 1303 (11th Cir. 1998). Under *Wolfe*, the limitations period in the plan must be enforced unless controlling law prohibits its modification of the default rule or the period provided in the plan is unreasonable. Neither of these circumstances exists in this case:

- No controlling law prohibits adoption of the limitations period specified in the Policy. As the dissent noted, "a federal rule concerning when a limitations period begins *in the absence of an agreement to adopt a shorter period* certainly is not a rule prohibiting adoption of a shorter period." 488 F.3d at 258 (emphasis added).
- The Policy's three-year contractual limitations period, which begins to run on the date proof of claim is required under the Policy, is not only reasonable but, as the dissent concluded, is "eminently reasonable – generous even" and "well constructed to prevent a suit too temporally removed from the events underlying it." 488 F.3d at 263. The Respondent never claimed that the limitations period was unreasonable or unclear, nor could she.

The Policy expressly stated that "[n]o legal action may start . . . more than 3 years after the time Proof of Claim is

required," which equated to August 9, 2003. Petitioner denied Respondent's claim on August 15, 2000 and then denied her appeal on March 28, 2001. Respondent, who was represented by counsel, had no further administrative remedies to exhaust and had *more than 28 months* to file suit. Yet, for some as yet unexplained reason, Respondent waited until March 26, 2004 to file suit – more than seven months too late. The sole criterion for evaluating the Policy limitations period under *Wolfe* was whether the period was reasonable. Under the circumstances, there is no dispute that the period was reasonable.

III. THE FOURTH CIRCUIT DECISION IS INCORRECT AND CREATES AN INTOLERABLE BURDEN FOR ERISA PLANS AND THEIR FIDUCIARIES.

The Fourth Circuit decision is incorrect because it is contrary to *Wolfe*. There is no question that the Policy limitations period allowed Respondent reasonable time to file suit after the final denial of her claim. That should have been the sole consideration under *Wolfe*. The Fourth Circuit majority refused to follow *Wolfe* on the ground that the plan's limitations period would require case-by-case review to decide whether the period of time left after a claim was denied was "reasonable." However, this logic ignores the fact that, under *Wolfe,* federal courts are already required to determine if a period is reasonable whenever a contract alters the otherwise applicable statutory limitations period. The question of reasonableness which the Fourth Circuit sought to avoid is no different than myriad other questions such as tolling and estoppel that require analysis of underlying facts and that routinely arise whenever a limitations period is in question. The fact

that the same questions might arise in the context of the plan's limitations period is certainly no reason to ignore it. The fact that the Fourth Circuit decision is contrary to *Wolfe* demonstrates that the decision has an impact well beyond ERISA, affecting the very basics of parties' freedom to determine the terms of their contract.

The Fourth Circuit decision is incorrect and creates an intolerable burden for ERISA plans and their administrators and fiduciaries because it relies on vague policy principles to vitiate the unambiguous terms of an ERISA plan. ERISA plan terms are paramount. The statute requires ERISA plans to be "established and maintained pursuant to a written instrument." 29 U.S.C. §1102(a)(1). Informal amendment of ERISA plans is prohibited and ERISA plan terms can only be amended where the plan "provide[s] a procedure for amending such plan, and for identifying the persons who have authority to amend the plan." 29 U.S.C. §1102(b)(3). ERISA plan fiduciaries are required to discharge their duties "in accordance with the documents and instruments governing the plan." 29 U.S.C. §1104(a). ERISA even provides specific causes of action for participants, beneficiaries, and fiduciaries to enforce written plan terms. 29 U.S.C. §1132(a)(1)(B) (permitting participants and beneficiaries to recover benefits due "under the terms of [the] plan" and to enforce their rights "under the terms of the plan"); §1132(a)(3) (permitting participants, beneficiaries, and fiduciaries to obtain injunctive and other appropriate equitable relief "to enforce . . . the terms of the plan" or to redress violations of "the terms of the plan"). ERISA's requirement that benefit plans be in writing is a "core functional requirement" of the statutory scheme and "'[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.'" *Curtiss-Wright Corporation v. Schoonejongen*, 514 U.S. 73, 83 (1995) (emphasis by Supreme Court) (quoting H.R. Rep. No. 93-1280, p. 297 (1974)). Here, *on examining the plan documents,* Respondent knew the deadline for filing suit from the moment she became disabled. The Fourth Circuit majority's application of a federal common law default accrual rule that is nowhere in ERISA and that directly contradicts the Policy, can only create confusion, the very thing that Congress intended to avoid when it mandated that benefit plans be in writing. This confusion is further exacerbated by the fact that the other circuit court decisions on which the majority relied adopt different default accrual rules than the rule ultimately adopted by the majority.

The Fourth Circuit decision is incorrect and creates an intolerable burden for ERISA plans and their administrators and fiduciaries because it opens up all plan terms to possible prohibition on the ground that they are in "tension" with general policies of ERISA. ERISA contains very little regulation of the substantive terms of ERISA welfare plans. This absence of specific regulation is generally viewed as leaving plan administrators broad discretion to tailor plans to their needs. *Black & Decker v. Nord, supra.* Indeed, creation of and changes to plan language are not even considered fiduciary functions under ERISA and remain virtually unregulated. *See, e.g., Hughes Aircraft Co. v. Jacobson,* 525 U.S. 432, 443 (1999) (the creation and amendment of plan terms is not a fiduciary function under ERISA and is not regulated by ERISA); *Lockheed Corp. v. Spink,* 517 U.S. 882, 890 (1996) (employers who alter terms of ERISA plans do not act as fiduciaries); *Curtiss-Wright v. Schoonejongen,* 514 U.S. at 100 ("Employers and

other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans."). Plan sponsor discretion may be somewhat limited when a plan is funded by insurance because insurance policies are subject to state insurance laws. But the decision below demonstrates that even state insurance laws are susceptible to prohibition at the hands of general default rules that are solely the creatures of federal common law.

The Fourth Circuit decision is incorrect and creates an intolerable burden for ERISA plans and their administrators and fiduciaries because it evidences a patent inconsistency in the enforcement of ERISA plan limitations periods. It is likely that the Fourth Circuit would have upheld a limitations period of 28 months (and probably a much shorter period) if the period began when the claim was denied. One can say this because the Fourth Circuit majority did not dispute that the 28-month period was reasonable and because federal courts have routinely found contractual limitations periods in ERISA-governed employee benefit plans as short as 45 days, 90 days, and one year to be reasonable. *Davidson v. Wal-Mart Assoc. Health and Welfare Plan*, 305 F. Supp.2d 1059 (S.D. Iowa 2004) (45-day limitations period enforced as bar to plaintiff's claim); *Northlake Reg'l Med. Ctr. v. Waffle House Sys. Employee Benefit Plan*, 160 F.3d 1301 (11th Cir. 1998) (enforcing 90-day limitations period); *Koonan v. Blue Cross & Blue Shield of Virginia*, 802 F. Supp. 1424 (E.D. Va. 1992) (enforcing a plan's one-year limitations period). These short limitations periods are almost presumed reasonable due to the nature of an ERISA claim for benefits:

> A suit under ERISA, following as it does upon the completion of an ERISA-required internal appeals process, is the equivalent of a suit to set aside an administrative decision, and ordinarily no more than 30 or 60 days is allowed within which to file such a suit . . . Like a suit to challenge an administrative decision, a suit under ERISA is a review proceeding, not an evidentiary proceeding. It is like an appeal, which in the federal courts must be filed within 10, 30, or 60 days of the judgment appealed from . . . depending on the nature of the litigation, rather than like an original lawsuit.

Doe v. Blue Cross & Blue Shield United of Wisconsin, 112 F.3d 869, 875 (7th Cir. 1997). Yet here, where the Respondent was left with a much longer amount of time to file suit after her claim was denied (over 28 months), the limitations period was deemed unenforceable, solely because it began when her proof of claim was due and because the accrual clause created the *hypothetical possibility* that a shorter time period might result from facts not present in this case. Certainly, unambiguous plan terms should not be deemed inapplicable based solely on hypothetical facts that have nothing to do with the case at hand.

The upshot of the Fourth Circuit decision is that 28 months was not deemed reasonable merely because the limitations period accrued when Respondent's proof of claim was due, whereas much shorter periods of 45 days, 90 days, and one year have routinely been held reasonable under ERISA and likely would have been upheld in this case. The root of this inconsistency appears to be the majority's assumption that Respondent had a limitations

period of three years under the Policy. She did not; Respondent had three years "*after the time Proof of Claim is required.*" As the dissent noted in discussing *Doe, supra,*

> In applying the *Wolfe* reasonableness rule, *Doe* considered the appropriateness of the 'limitations *period*' . . . which it correctly understood to include the event that commences the period as well as the length of the period.

488 F.3d at 262 (emphasis in original). The majority failed to understand that the Policy limitations clause is a unit consisting of both a commencement date *and* a length of time. This failure led the majority to rob the Policy limitations provision of its operative language.

IV. THIS CASE PROVIDES THE IDEAL VEHICLE FOR RESOLVING THE CIRCUIT SPLIT.

There are several reasons why this case provides the ideal vehicle for resolving the circuit split and the conflict with *Wolfe*. The Policy language at issue is unambiguous, so there are no debates about proper interpretation. The Policy language is also virtually universal, being mandated for inclusion in disability and similar insurance policies by forty-nine states, so the impact of the Fourth Circuit decision goes well beyond this case. In fact, literally hundreds of insured ERISA welfare plans have been told, in essence, that although plan terms may be clear and unambiguous and may even be mandated by state insurance laws, they are still subject to challenge based on vague notions of public policy. The claim review process in this case was uneventful, in full compliance with applicable procedural regulations, and free of any undue delays. Indeed, the hypothetical drawbacks that might conceivably result

from an accrual at the time proof of claim is due, as identified by the district court and the Fourth Circuit majority, were not even present in this case. From a procedural standpoint, this case presents the ideal scenario for resolution of the issue presented. Finally, this case also has the ideal factual background for review because the claim process was completed in time to leave Respondent with over 28 months to file suit, a time period that everyone conceded was reasonable. The legal issue of whether a proof of claim accrual clause can be applied in an ERISA benefits dispute is squarely before the Court and is ripe for review.

CONCLUSION

For the reasons stated herein, Petitioner respectfully requests that this Court grant review and reverse the ruling below.

Respectfully Submitted,

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