No. 12-729

In the Supreme Court of the United States

JULIE HEIMESHOFF, PETITIONER

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO., ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTION PRESENTED

Under Section 1132(a)(1)(B) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1132(a)(1)(B), a participant in an employee benefit plan may bring a civil action to recover benefits due to him under the terms of the plan. Courts of appeals uniformly require a participant to exhaust available plan remedies before bringing such an action. The question presented is:

Whether the statute of limitations for seeking judicial review of a plan's adverse benefits determination begins running only after the participant has appropriately exhausted plan remedies, notwithstanding a plan provision providing that the limitations period commences before the plan has resolved the claim for benefits.

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INTEREST OF THE UNITED STATES

The question presented in this case is whether a plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, may provide that the limitations period for seeking judicial review of the plan's denial of benefits begins running before the plan has issued its final determination. The Secretary of Labor has primary authority for administering and enforcing Title I of ERISA, including the authority to implement through regulations the Act's claims administration process. Accordingly, the Secretary has a substantial interest in the proper resolution of this case.

STATEMENT

1. ERISA was enacted to "protect * * * the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. 1001(b). While employers have

broad discretion under the statute to decide whether to provide employee benefit plans and what benefits to offer, *Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 78 (1995), ERISA protects plan participants' entitlement to those benefits by establishing a comprehensive remedial framework that sets forth "standards of conduct, responsibility, and obligation for fiduciaries of [those] plans" and provides "appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. 1001(b).

ERISA establishes a two-tiered framework enabling a plan participant or beneficiary to assert her right to benefits under the plan. The first avenue of redress consists of internal plan claims procedures. When a plan administrator initially denies a claim for benefits, ERISA requires it to "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. 1133(1). The plan must then "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. 1133(2).

The second avenue of redress is judicial review of the plan's "wrongful denial of benefits." *Varity Corp.* v. *Howe*, 516 U.S. 489, 512 (1996). A participant whose claim has been denied may bring a civil action "to recover benefits due to him under the terms of his plan." 29 U.S.C. 1132(a)(1)(B). In such a suit, the court "review[s] the decision[] of [the] ERISA plan administrator." *Conkright* v. *Frommert*, 130 S. Ct. 1640, 1646 (2010).

2. Petitioner, an employee of WalMart Stores, Inc. (WalMart), stopped working on June 8, 2005, as a result of several medical conditions. Pet. App. 6. On August 22, 2005, petitioner filed a claim for long-term disability benefits with respondent Hartford Life & Accident Insurance Co. (Hartford), the plan administrator of WalMart's group disability-benefits plan. *Id.* at 7.

Under WalMart's Hartford policy, an employee seeking benefits must provide written "proof of loss" to Hartford within 90 days after the start of the period for which Hartford owes payment or, if it is not possible to provide proof by that date, within one year of the original deadline. Pet. App. 7, 56. The policy further provides that "[l]egal action cannot be taken against [Hartford] * * * sooner than 60 days after due proof of loss has been furnished; or * * * [more than] 3 years after the time written proof of loss is required to be furnished." *Id.* at 56.

In November 2005, Hartford notified petitioner that it did not have sufficient information to make a claim determination. Pet. App. 7, 72-74. On December 8, 2005, the date on which proof of loss was due, see Br. in Opp. 4, Hartford denied petitioner's claim for failure to provide satisfactory proof of loss. Pet. App. 8, 75-79. Hartford also informed petitioner that she had a right to file an internal appeal within 180 days, *id.* at 78, but it later indicated that it would reopen the record, without the need for a formal appeal, if petitioner provided additional information. *Id.* at 8. On November 26, 2007, after petitioner submitted additional medical evidence, Hartford issued its final decision denying petitioner's claim. *Id.* at 9.

3. On November 18, 2010, less than three years after Hartford's final decision, petitioner brought this suit

under Section 1132(a)(1)(B), seeking judicial review of Hartford's denial of her claim. Pet. App. 15. Respondents moved to dismiss the complaint on the ground that petitioner had failed to file suit within the limitations period set forth in the plan, *i.e.*, three years after the deadline for submitting written proof of loss. *Id.* at 5.

The district court granted the motion. Pet. App. 5-18. As relevant here, the court explained that because ERISA does not prescribe a limitations period for benefits claims, the applicable period is the most nearly analogous state statute. *Id.* at 13. Looking to Connecticut law, the court concluded that state law permitted insurance carriers to "contract for a limitations period in which a claim may be filed as long as that period is not less than one year." *Ibid.* Further, the court reasoned, Second Circuit precedent held that a "limitations period that begins to run before a claimant may bring legal action is enforceable." *Ibid.* (citing *Burke* v. *PriceWaterhouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 79-81 (2d Cir. 2009) (per curiam)). The court therefore applied the plan's limitations provision and concluded that petitioner's suit was untimely. Although the parties disputed the relevant proof of loss deadline, the court held that the latest that proof of loss was due was September 30, 2007, the date of the extension Hartford had granted in connection with petitioner's internal appeal. *Id.* at 14. Because petitioner had filed suit more than three years after September 30, 2007, the court dismissed the complaint. *Id.* at 15.

4. The Second Circuit affirmed in an unpublished per curiam opinion. Pet. App. 1-4. The court held that "[i]n this Circuit, a statute of limitations specified by an ERISA plan for bringing a claim under 29 U.S.C. [] 1132 may begin to run before a claimant can bring a legal

action." *Id.* at 3 (citing *Burke*, 572 F.3d at 81). The court therefore concluded that petitioner's suit was untimely because she filed it "more than three years after her proof of loss was due." *Ibid.*

SUMMARY OF ARGUMENT

An employee benefits plan governed by ERISA may not prescribe a limitations period for seeking review of the plan's denial of benefits that commences before the plan has made its final decision. Such provisions are inconsistent with ERISA's remedial scheme because they permit the participant's exhaustion of plan remedies—which is mandatory—to consume all or part of the time for seeking judicial review of the plan's final determination. Setting the two statutory avenues of redress against each other in this manner undermines the availability and efficacy of both.

A. ERISA protects employees' entitlement to contractually defined benefits by establishing a comprehensive enforcement scheme. When a plan participant's claim for benefits is initially denied, ERISA provides procedures for relief in two stages: first, an internal plan review process, 29 U.S.C. 1133(2), and then judicial review of the plan's final determination, 29 U.S.C. 1132(a)(1)(B). The internal claims process serves the critical purpose of permitting the parties to resolve disputes efficiently, without resorting to litigation, and it also enables the creation of a full record for those cases in which judicial review becomes necessary. Accordingly, courts have uniformly held that exhaustion of available plan remedies is a prerequisite to seeking judicial review.

B. The limitations period for seeking judicial review under Section 1132(a)(1)(B) begins to run when the plaintiff's cause of action accrues—that is, when the

claimant has exhausted internal plan remedies and the plan administrator has issued its final decision. Under federal common law limitations principles, which govern the time for filing suit under Section 1132(a)(1)(B), the "standard rule" is that the limitations period begins to run when the plaintiff's cause of action has accrued—in other words, when "the plaintiff can file suit and obtain relief." *Bay Area Laundry & Dry Cleaning Pension Trust Fund* v. *Ferbar Corp.*, 522 U.S. 192, 201 (1997). Congress legislated against that background rule in enacting ERISA, and therefore would reasonably have expected it to apply to claims brought under Section 1132(a)(1)(B).

Consistent with the general rule when a plaintiff is required to exhaust administrative or other non-judicial remedies before filing suit, a plaintiff's cause of action under Section 1132(a)(1)(B) accrues when exhaustion of the plan's statutorily mandated review procedures is complete and the plan has issued its final decision. See *Crown Coat Front Co.* v. *United States*, 386 U.S. 503, 514 (1967). Before that point, the plan has not definitively rejected the plaintiff's claim, and she does not "know what claim [she] has or on what grounds administrative action may be vulnerable." *Id.* at 513-514. The statute of limitations for a Section 1132(a)(1)(B) claim therefore commences when the plan finally denies the plaintiff's claim.

C. An ERISA plan may not include terms that purport to deviate from that rule by providing that the limitations period for filing suit in court begins before the claimant has exhausted remedies under the plan's review procedures. Such terms are inconsistent with ERISA's remedial scheme because they undermine the

efficacy of both the internal claims procedures and judicial review.

ERISA's requirement of "full and fair" internal review procedures, 29 U.S.C. 1133(2), is intended to ensure that the plan's final decision is rendered only after a non-adversarial process in which the plan fiduciary has had a meaningful dialogue with the claimant. If the limitations period began to run before exhaustion was complete, the internal claims procedure could consume all or part of a participant's time for preparing and filing a suit challenging the plan's eventual decision. In addition to impeding participants' ability to seek judicial review, the uncertainty about the time for filing suit would encourage participants to attempt to expedite internal review by cutting short interaction with the plan and proceeding in a more truncated and adversarial way. The internal review procedure would thus be less likely to function as an efficient means of resolving claims without litigation. The factual record that resulted would be less developed, thereby hindering judicial review.

Respondents suggest that those concerns could be alleviated through a case-by-case inquiry permitting equitable tolling in the "rare" cases in which the participant is left with an unreasonably short time to file suit. Br. in Opp. 25. But that ad hoc approach would not furnish the clear, predictable rules necessary to avoid distorting the parties' incentives and undermining the remedial framework. It would also create additional burdensome litigation over participants' entitlement to tolling.

D. Respondent's reliance on state laws permitting insurance policies to provide that the limitations period begins to run when proof of loss is due is misplaced. Such laws are inconsistent with ERISA's remedial

framework and therefore cannot supply the federal common law rule of decision. In addition, such statutes are designed to operate in state-law breach-of-contract actions, where exhaustion of non-judicial remedies is not generally required and tying the limitations period to when proof of loss is due does not have adverse consequences.

ARGUMENT

AN ERISA PLAN MAY NOT PROVIDE THAT THE STATUTE OF LIMITATIONS FOR SEEKING JUDICIAL REVIEW OF A PLAN FIDUCIARY'S BENEFITS DETERMINATION BEGINS TO RUN BEFORE THE PLAN FIDUCIARY HAS ISSUED ITS FINAL DECISION

A. ERISA's Comprehensive Remedial Scheme Is Structured To Provide Plan Beneficiaries With Two Complementary And Sequential Avenues—Internal Plan Review And Judicial Review—For Challenging A Plan's Benefits Determination

1. Congress enacted ERISA to "protect * * * participants in employee benefit plans and their beneficiaries" by ensuring that employees receive the benefits they have earned. 29 U.S.C. 1001(b); see *Conkright* v. *Frommert*, 130 S. Ct. 1640, 1648 (2010); *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 148 (1985) (ERISA "protect[s] contractually defined benefits"). An "essential tool[] for accomplishing" ERISA's protective purposes is its comprehensive enforcement framework. *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 52 (1987); see *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 208 (2004). That framework is designed to provide employees with "appropriate remedies * * * and ready access to the Federal courts." 29 U.S.C. 1001(b). Specifically, ERISA creates two interlocking procedures for plan

participants seeking benefits under an employee benefits plan: an internal plan claims review mechanism, 29 U.S.C. 1133, and a federal right of action for judicial review of the plan's benefits determination, 29 U.S.C. 1132(a)(1)(B).

When a plan administrator initially denies a claim for benefits, ERISA requires the administrator to provide adequate notice to the participant and to "afford a reasonable opportunity * * * for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. 1133. In doing so, the plan must "comply with Department of Labor regulations on * * * affording a reasonable opportunity for review," *Pilot Life*, 481 U.S. at 53, which set "minimum requirements" designed to ensure the fairness and efficacy of the internal claims procedures, 29 C.F.R. 2560.503-1(a). Those statutory and regulatory requirements "underscore[] the particular importance of accurate claims processing," and they "impose[] higher-than-marketplace quality standards on * * * a plan administrator" by requiring it to "'discharge [its] duties' in respect to discretionary claims processing 'solely in the interests of the participants and beneficiaries' of the plan." *Metropolitan Life Ins. Co.* v. *Glenn*, 554 U.S. 105, 115 (2008) (quoting 29 U.S.C. 1104(a)(1)).

A "person denied benefits under an employee benefit plan [may] challenge that denial in federal court." *Glenn*, 554 U.S. at 108; 29 U.S.C. 1132(a)(1)(B). When a plan participant sues to recover benefits allegedly due under the plan, the court "review[s] the decision[] of [the] ERISA plan administrator." *Conkright*, 130 S. Ct. at 1646. That review is ordinarily deferential: when, as is usually the case, plan documents grant the administrator discretion to "determine eligibility for benefits or

to construe the terms of the plan," the plan's determination is reviewed for abuse of discretion. *Ibid.*

2. These two procedures for redress of benefit claims work in conjunction to preserve ERISA's "'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans." *Davila*, 542 U.S. at 215. Congress provided a right of action to challenge plan benefits decisions because it recognized that "access to the courts" and meaningful judicial review according to uniform standards is critical to plan participants' ability to enforce their rights. H.R. Rep. No. 533, 93d Cong., 1st Sess. 12 (1973) (*House Report*). At the same time, ERISA's requirement of internal claims resolution procedures enables parties to resolve disputes without resorting to costly litigation, and in a more efficient, nonadversarial manner. *Conkright*, 130 S. Ct. at 1649. The internal review procedures also aid any subsequent judicial review by enabling the parties to create a full record and affording the plan administrator an opportunity to apply its expertise in interpreting the plan in the first instance. *Ibid.*; *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 110-111 (1989).

In view of the importance of the plan's internal claims process to the statutory remedial scheme, the courts of appeals have uniformly held that although ERISA does not expressly mandate exhaustion of plan remedies, exhaustion is an "implicit prerequisite" to seeking judicial review under Section 1132(a)(1)(B). *McGraw* v. *Prudential Ins. Co.*, 137 F.3d 1253, 1263 (10th Cir. 1998)[1]; see *LaRue* v. *DeWolff, Boberg & Assoc.*, 552 U.S.

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[1] See also *Madera* v. *Marsh USA, Inc.*, 426 F.3d 56, 61 (1st Cir. 2005); *Burke* v. *Price Waterhouse Coopers LLP Long Term Disability Plan*, 572 F.3d 76, 79 (2d Cir. 2009) (per curiam); *Weldon* v. *Kraft,*

248, 258-259 (2008) (Roberts, C.J., and Kennedy, J., concurring). Similarly, the Labor Department's regulations assume that, absent unusual circumstances such as a plan's failure to provide full and fair procedures, exhaustion is ordinarily required and "claimants would be entitled to have a claim dispute adjudicated in court pursuant to section [1132(a)] of the Act *after* exhausting the plan's claims procedures." 65 Fed. Reg. 70,254 & n.33 (Nov. 21, 2000) (emphasis added); see 29 C.F.R. 2560.503-1(*l*). For instance, the regulations require the plan administrator to provide the claimant with notice of her right to bring suit under Section 1132(a) "following [the] adverse benefit determination *on review*." 29 C.F.R. 2560.503-1(g)(1)(iv) (emphasis added), 2560.503-1(j)(4). They also state that when the plan fails to establish procedures in accordance with the statute and regulations, beneficiaries "shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under" Section 1132. See 29 C.F.R. 2560.503-1(*l*).

Inc., 896 F.2d 793, 800 (3d Cir. 1990); *Makar* v. *Health Care Corp. of Mid-Atlantic (Carefirst)*, 872 F.2d 80, 83 (4th Cir. 1989); *Bourgeois* v. *Pension Plan for Emps. of Santa Fe Int'l Corps.*, 215 F.3d 475, 479 (5th Cir. 2000); *Weiner* v. *Klais & Co.*, 108 F.3d 86, 90 (6th Cir. 1997); *Doe* v. *Blue Cross & Blue Shield United*, 112 F.3d 869, 873 (7th Cir. 1997); *Wert* v. *Liberty Life Assurance Co.*, 447 F.3d 1060, 1063 (8th Cir. 2006); *Barboza* v. *California Ass'n of Prof'l Firefighters*, 651 F.3d 1073, 1076 (9th Cir. 2011); *Perrino* v. *Southern Bell Tel. & Tel. Co.*, 209 F.3d 1309, 1315 (11th Cir. 2000); *Communications Workers of Am.* v. *American Tel. & Tel. Co.*, 40 F.3d 426, 431 (D.C. Cir. 1994).

B. The Statute Of Limitations For Bringing An Action Under Section 1132(a)(1)(B) Begins To Run When The Claimant Has Exhausted Plan Remedies And The Plan Has Issued Its Final Decision

ERISA does not provide a statute of limitations to govern the time in which a plan participant may file suit under Section 1132(a)(1)(B) to challenge a plan's denial of benefits. As a result, federal common law fills that gap. See *Wallace* v. *Kato*, 549 U.S. 384, 388 (2007). Under well-established principles of federal law, against which Congress legislated in enacting ERISA, the limitations period for seeking judicial review under Section 1132(a)(1)(B) commences when the plaintiff's cause of action accrues—*i.e.*, when the plan issues its final decision denying the claim for benefits.

1. When a federal statute does not provide a limitations period for the cause of action it creates, federal law borrows a limitations period as a matter of federal common law. See *North Star Steel Co.* v. *Thomas*, 515 U.S. 29, 33 (1995). Ordinarily, federal law borrows the most analogous state statute of limitations, unless the state period is inconsistent with federal policy. See *Graham Cty. Soil & Water Conservation Dist.* v. *United States*, 545 U.S. 409, 415 (2005).

Because the plaintiff's cause of action arises under federal law, the "question [of] what limitations *principles* shall govern the borrowed limitations *period* is in the first instance one of federal law, to be decided in accordance with the policies discernible in or imputable to the federal statute for which the state limitations period has been borrowed." *Doe* v. *Blue Cross & Blue Shield United*, 112 F.3d 869, 873 (7th Cir. 1997). The limitations principles applied to a federal cause of action thus must be consistent with the statutory framework,

and courts will borrow state principles only when "their full application would [not] defeat the goals of the federal statute at issue." *Hardin* v. *Straub*, 490 U.S. 536, 539 (1989) (state-law principles interrelated with the length of the state limitations period, such as tolling, are ordinarily borrowed, unless inconsistent with federal policy); see also *West* v. *Conrail*, 481 U.S. 35, 39 (1987) (Court borrows only so much of state limitations law as is necessary to fill gap in federal statute and is consistent with federal policy).

Whether or not a federal statute provides a limitations period, the "standard rule" under federal law is that the statute of limitations does not begin to run until the plaintiff's cause of action has accrued—in other words, when "the plaintiff can file suit and obtain relief." W*allace*, 549 U.S. at 388; *Bay Area Laundry & Dry Cleaning Pension Trust Fund* v. *Ferbar Corp.*, 522 U.S. 192, 200-201 (1997) (describing this rule as reflecting "basic limitations principles"); *Reiter* v. *Cooper*, 507 U.S. 258, 267 (1993); *Clark* v. *Iowa City*, 87 U.S. (20 Wall.) 583, 589 (1875) ("All statutes of limitation begin to run when the right of action is complete"); see also Horace G. Wood, *Limitations of Actions at Law and at Equity* § 117, at 616 (1916); *id.* § 122a, at 684. That rule reflects the fact that "[i]t would clearly be unfair to charge the plaintiff with the expiration of any time before the plaintiff's cause of action could be prosecuted to a successful conclusion." 1 Calvin W. Corman, *Limitation of Actions* § 6.1, at 370 (1991). Permitting the limitations period to run before the plaintiff can sue could "bar[] [the plaintiff] from the courts," a result that would be "unfortunate" and "untoward." *Crown Coat Front Co.* v. *United States*, 386 U.S. 503, 514-515 (1967). As a result, the Court will not infer that Congress intended the limita-

tions period to commence before the cause of action accrues absent an express indication in the statute. *Reiter*, 507 U.S. at 267 (declining to "infer such an odd result in the absence of any such indication in the statute"); see also *TRW Inc.* v. *Andrews*, 534 U.S. 19, 38 (2001) (Scalia, J., concurring in the judgment) (Congress legislates against this background rule of accrual).

2. Congress enacted ERISA against the backdrop of the traditional rule that the limitations period begins to run when the cause of action accrues. The statute does not expressly provide a different accrual date for Section 1132(a)(1)(B); Congress therefore would reasonably expect that courts would apply standard federal common law limitations principles. See *Wallace*, 549 U.S. at 388 (applying standard accrual rule where Congress did not provide a statute of limitations and state period was borrowed); *TRW Inc.*, 534 U.S. at 38 (Scalia, J., concurring in the judgment) ("When [Congress] has wanted us to apply a different rule * * * it has said so."); *Reiter*, 507 U.S. at 267. Thus, although the limitations period for Section 1132(a)(1)(B) claims is borrowed from state law, *Burke*, 572 F.3d at 78, federal law provides that the time to sue under Section 1132(a)(1)(B) begins running when the plaintiff is first able to file suit in court. See *Bay Area Laundry*, 522 U.S. at 201.

A plaintiff's Section 1132(a)(1)(B) claim for judicial review of the plan's denial of benefits accrues when she has exhausted internal remedies and the plan has made its final determination. Plan participants are required to exhaust the plan's internal remedies, and the Section 1132(a)(1)(B) action is one for judicial review of the plan's final decision, rather than a de novo action for benefits. See pp. 9-10, *supra*; *Metropolitan Life Ins. Co.* v. *Taylor*, 481 U.S. 58, 66 (1987) ("the civil enforcement

section * * * enable[s] participants and beneficiaries to bring suit to recover benefits denied contrary to the terms of the plan"). When "disputes are subject to mandatory administrative proceedings" before the plaintiff may resort to court, and the purpose of the suit is to obtain judicial review of the final result of the pre-suit proceedings, the general rule is that "the claim does not accrue until their conclusion." *United States* v. *Meyer*, 808 F.2d 912, 916 (1st Cir. 1987) (citation omitted); see *Crown Coat Front*, 386 U.S. at 513-514 (rejecting argument that cause of action for judicial review of administrative decision should accrue before completion of required administrative proceedings). That rationale behind the accrual rule applies with full force to ERISA claims. Before a plan participant has completed the required exhaustion, her "claim is not subject to adjudication in the courts." *Id.* at 511. The Section 1132(a)(1)(B) claim challenges the "wrongful denial of benefits," *Varity Corp.* v. *Howe*, 516 U.S. 489, 512 (1996), and no final and actionable denial has occurred before the plan administrator has rejected the participant's claim at the conclusion of the internal review process. Nor, prior to that time, can the claimant "know what claim he has or on what grounds administrative action may be vulnerable." *Crown Coat Front*, 386 U.S. at 513-514.

As a result, the governing rule under ERISA is that a plan participant's Section 1132(a)(1)(B) claim for benefits does not accrue until the participant has exhausted the plan's internal procedures and the plan has rendered the final decision that will be reviewed by the court.[2]

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[2] Consistent with this rule, in cases involving a plaintiff's challenge to a plan's denial of her application for benefits, the courts of appeals have generally held that a Section 1132(a)(1)(B) claim accrues when

See *Bay Area Laundry*, 522 U.S. at 201; see also, *e.g.*, *Wise* v. *Verizon Commc'ns, Inc.*, 600 F.3d 1180, 1188-1189 (9th Cir. 2010); *Martin* v. *Construction Laborer's Pension Trust*, 947 F.2d 1381, 1385-1386 (9th Cir. 1991).

C. An ERISA Plan May Not Provide That The Limitations Period Begins To Run Before The Plaintiff's Claim Accrues

1. Plan provisions governing the limitations period for seeking review of a plan's claim denial must be consistent with ERISA's remedial scheme

The question presented in this case is whether an ERISA plan may deviate from the limitations-accrual rule that governs in a suit under Section 1132(a)(1)(B) by providing that the limitations period for seeking judicial review begins to run before the participant has exhausted plan remedies, and before her cause of action for judicial review has accrued. The answer to that question turns on whether permitting a plan to uncouple the commencement of the limitations period from the accrual of the cause of action would be consistent with the policies embodied in ERISA.

The extent to which private parties may alter the governing limitations rules is, like other questions concerning the statute of limitations for a federal claim, a matter of federal common law that must be "decided in accordance with the policies discernible in" the underly-

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the plan makes its final decision on the plaintiff's claim, a rule sometimes expressed as requiring a "clear and continuing repudiation" by the plan of the plaintiff's claim. See, *e.g.*, *Withrow* v. *Halsey*, 655 F.3d 1032, 1036 (9th Cir. 2011); *Daill* v. *Sheet Metal Workers' Local 73 Pension Fund*, 100 F.3d 62, 67 (7th Cir. 1996); *Martin* v. *Construction Laborer's Pension Trust*, 947 F.2d 1381, 1386 (9th Cir. 1991).

ing federal statute. *Doe*, 112 F.3d at 873; see pp. 12-13, *supra*. Thus, although "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," the parties may agree to deviate from governing limitations rules only "in the absence of a controlling statute to the contrary." *Order of United Commercial Travelers of Am.* v. *Wolfe*, 331 U.S. 586, 608 (1947).

ERISA's structure demonstrates that plan terms that purport to govern a participant's ability to enforce her claim to benefits must be consistent with the statutory remedial scheme. While ERISA gives employers broad discretion to determine whether to offer employee benefits plans and what benefits to provide, see *Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 78 (1995), the Act closely regulates the enforcement of contractually defined benefits by establishing an "interlocking, interrelated, and interdependent remedial scheme." *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 146, 148 (1985). That remedial scheme is designed to guarantee "ready access to the Federal courts," 29 U.S.C. 1001(b), and to eliminate "jurisdictional and procedural obstacles which in the past appear to have hampered effective enforcement of fiduciary responsibilities," *House Report* 17. The reticulated nature of ERISA's civil enforcement provisions has led this Court to decline to "tamper with [the] enforcement scheme" by supplementing it with additional state or federal avenues of relief. *Pilot Life*, 481 U.S. at 54.

As a result, ERISA—not the plan—ultimately controls the claimant's right to judicial review under Section 1132(a)(1)(B). For instance, a plan provision purporting to exempt the plan administrator from liability

for suits brought under Section 1132(a)(1)(B) would be void, because it would be inconsistent with Congress's determination that ERISA's remedial provisions are necessary to protect employee interests. 29 U.S.C. 1110(a) ("any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under this part shall be void as against public policy"); cf. 29 U.S.C. 1104(a)(1)(D) (fiduciary must perform its duties "in accordance with" plan terms, "insofar as such documents and instruments are consistent with the provisions of this subchapter"); *House Report* 12 (explaining that pre-ERISA state trust law was insufficiently protective because it permitted trust documents to exempt trustees from certain legal duties). Similarly, although plans have leeway in structuring their internal claims processes, those procedures must be "full and fair," 29 U.S.C. 1133(2), and they must comply with the minimum requirements set forth in the Labor Department's regulations, 29 C.F.R. 2560.503-1. Any plan terms that purport to govern the internal-review process or the plan participant's access to judicial review must therefore be consistent with ERISA's remedial structure and the Secretary's implementing regulations.[3]

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[3] This Court's holding in *U.S. Airways, Inc.* v. *McCutchen*, 133 S. Ct. 1537 (2013)—that the defenses available in an action to enforce a plan's reimbursement provision are governed by the terms of the plan—is not to the contrary. There, the health plan brought suit under Section 1132(a)(3), which authorizes suits for "appropriate equitable relief * * * to enforce * * * the terms of the plan," seeking to enforce a provision entitling the plan to reimbursement of benefits paid when the beneficiary recovers damages from a third-party tortfeasor. The Court held that the plan's suit was analogous to an action to enforce an "equitable lien by agreement." *Id.* at 1546. Because

2. Plan terms providing that the limitations period begins to run before the plaintiff's claim has accrued are inconsistent with ERISA's remedial scheme

An ERISA plan cannot lawfully provide that the limitations period commences on the date the participant must provide proof of loss—*i.e.*, early in the plan review process, well before the participant may seek judicial review. Such a provision is inconsistent with ERISA's two-tiered remedial scheme because it sets the two procedures for redress—internal claims processes and judicial review—against each other, thereby undermining the availability and efficacy of both.

a. Plan terms that trigger the limitations period before the internal plan process is complete risk substantially shortening or even consuming the time for the plaintiff to seek judicial review of the plan's final decision. "[E]very day the plan took for its decision-making would be one day less that a claimant would have to review the plan's final decision, decide whether to challenge it in court, and prepare a civil action if need be." *White* v. *Sun Life Assurance Co.*, 488 F.3d 240, 247-248 (4th Cir.), cert. denied, 552 U.S. 1022 (2007). That odd result would give "[b]enefit plans * * * the incentive to delay the resolution of their participants' claims." *Id.* at 427. The more significant concern, however, is that

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such a suit traditionally sought to enforce the terms of the agreement, and "[t]he agreement itself [became] the measure of the parties' equities," the Court held that the plan's terms, not general equitable principles of unjust enrichment, governed the parties' rights. *Id.* at 1548. That holding was based on the principles applicable to the most analogous action in equity, rather than any conclusion that plans may limit or regulate the judicial remedies provided by ERISA. The Court did not suggest that plans may override ERISA's judicial-review provisions or limit a claimant's right to bring a Section 1132(a)(1)(B) suit.

plan administrators acting in good faith would consume the limitations period: the internal review process is intended to be an iterative one, in which a "meaningful dialogue" between plan and participant fosters more accurate, equitable results. *Booton* v. *Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997) (citing regulations).

Conducting the internal claims process in the manner intended by Congress would therefore encroach on the time for seeking judicial review under the limitations imposed by the plan. Although respondents argue (Br. in Opp. 23) that the Secretary's claims-processing regulations assuage that concern by "strictly limit[ing] the amount of time a plan administrator has to make an initial benefits determination and decide an administrative appeal," the regulatory time periods are in fact designed to be flexible in order to encourage full and thorough internal consideration. Most importantly, the regulations permit plan administrators to toll the applicable time limits for potentially extended periods by requesting more information from the claimant. 29 C.F.R. 2560.503-1(f)(4). By way of illustration, in this case Hartford claims to have complied with the regulatory time limits by issuing a final decision on petitioner's claim 718 days, or nearly two years, after her proof of loss was due. See Br. in Opp. 4-6. And even in the absence of authorized tolling, the regulations permit a group benefits plan to take up to 345 days to issue its final decision: the plan could in appropriate circumstances take 75 days to make its initial determination concerning a disability benefits claim, 29 C.F.R. 2560.503-1(f)(3), must permit the claimant *at least* 180 days to file an internal appeal, 29 C.F.R. 2560.503-1(h)(3)(i), and could take up to 90 days to decide the

appeal, 29 C.F.R. 2560.503-1(i)(1)(i) and (3)(i). The internal claims process thus may often entirely consume, or materially shorten, the time in which the plaintiff may seek judicial review.

That result is directly contrary to ERISA's reliance on judicial enforcement as a crucial means of ensuring that the plan's decision is reasonable and was reached after full and fair procedures. See *Davila*, 542 U.S. at 208; *Conkright*, 130 S. Ct. at 1649. When a statute "evidences a congressional purpose to insure adequate judicial review of [internal] decisions," as ERISA does, "it is very doubtful that [Congress] anticipated no review at all if administrative proceedings, compulsory on the [participant], continued for" longer than the limitations period. *Crown Coat Front*, 386 U.S. at 514 (holding that permitting limitations period to commence before conclusion of administrative procedures could thwart judicial review, which "is not an appealing result, nor * * * one that Congress intended"); see also *Varity Corp.*, 516 U.S. at 513 (ERISA is designed to develop "a sensible administrative system").

Even when the internal review proceedings do not consume the entire limitations period, a participant may face a substantially shortened time in which to prepare to file suit. Before the plan has issued its final decision, the participant does not know whether she will need to file suit, or whether, if the plan denies her claim, she will have viable arguments to make in court. A plaintiff therefore cannot begin preparing her lawsuit before the plan has issued its final decision. While a plaintiff might attempt to mitigate this risk by filing a protective declaratory-judgment action for benefits, see 29 U.S.C. 1132(a)(1)(B), she cannot "sensibly ask the courts to review a decision which has not yet been made," and

such premature suits would likely serve only to create procedural complications and additional litigation. *Crown Coat Front*, 386 U.S. at 515.

b. Subjecting plan participants to uncertainty about their ability to prepare for and seek judicial review would also undermine the efficacy of the plan's internal procedures. Section 1133(2)'s requirement that a plan provide "full and fair review" procedures and the regulations implementing that requirement are designed to ensure that the plan's final benefits decision is based on a meaningful, thorough, and non-adversarial exchange between the plan fiduciary and the claimant. *Booton*, 110 F.3d at 1463. Permitting plans to provide that the limitations period runs during the plan's internal claims process would create perverse incentives for beneficiaries: any dialogue with plan fiduciaries about the merits of their claim might eat into the time to seek court review of a final decision. Beneficiaries might therefore seek to cut short exchanges with plan administrators, or treat the process in a more adversarial manner, in the hope of preserving adequate time to seek judicial review. Claimants might also feel compelled to hire attorneys earlier in the process, and in more cases. These consequences would vitiate the purposes served by internal review proceedings—the same purposes that have led courts to require exhaustion of these proceedings. See pp. 10-11, *supra*. Fewer claims would be resolved without litigation; plan administrators' ability to resolve claims accurately in the first instance would be hindered; and the factual record on which judicial review must be conducted would be less complete. Those ad-

verse consequences would in turn undermine the efficacy of judicial review.[4]

Permitting the limitations period to commence at the outset of the plan's internal review process would also work at cross-purposes to the Secretary's claims-processing regulations. The purpose of permitting plan administrators to toll the regulatory time limits by requesting more information is to enable dialogue between plan and participant, see 65 Fed. Reg. at 70,250, but that purpose would be defeated by the incentives created by respondents' rule. That regulation's tolling provisions should not be permitted to threaten beneficiaries' ability to seek judicial review. In addition, although the regulations entitle a beneficiary to at least 180 days to appeal a group health plan's initial adverse benefits determination, 29 C.F.R. 2560.503-1(h)(3)(i), respondents' rule would likely cause beneficiaries to forgo some of that time in an attempt to protect their ability to seek judicial review. That would be contrary to the Department's conclusion that 180 days strikes the appropriate balance between the participant's need for adequate time to prepare the appeal and the plan's interest in expeditiously resolving benefits claims.

c. Finally, permitting an ERISA plan to uncouple the commencement of the limitations period from claim accrual would be inconsistent with principles of trust

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[4] When an ERISA plan contains a provision that shortens the otherwise-applicable state limitations period, but does not provide that the limitations period begins to run before the claim has accrued, the beneficiary is not subjected to these uncertainties or forced into the dilemma that undermines the efficacy of the remedial scheme. Thus, although the question is not presented here, provisions that simply shorten the limitations period following the plan's issuance of its final decision, if reasonable, may be consistent with ERISA and therefore permissible. See *White*, 488 F.3d at 250.

law, which provides guidance in interpreting ERISA. *Varity Corp.*, 516 U.S. at 496-497 (Congress drew on trust law in enacting ERISA). In establishing a trust, the settlor has broad discretion to determine the purpose and terms of the trust. But the settlor may not include terms that purport to deprive the court of jurisdiction to review the trustee's actions. See Unif. Trust Code § 105 (2000, last revised or amended 2010); Alan Newman, George G. Bogert & George T. Bogert, *The Law of Trusts and Trustees* § 961, at 1-2 (3d ed. 2010) (Bogert). Relatedly, the settlor may not relieve the trustee of its duty to provide an accounting of its management of the trust property to the beneficiary, because the right to an accounting is critical to the beneficiary's ability to discover potential claims against the trustee and to enforce them in court. Bogert § 965, at 111-119. Here, the internal claims procedure required by ERISA is analogous to a trust accounting, in the sense that the ERISA participant cannot know whether she has a judicial claim against the plan, and on what grounds, until she has exhausted the internal procedure and received the plan's final determination.

The limitations period for a breach-of-trust claim does not commence until the beneficiary's cause of action has accrued—namely, when "the trust is closed, or * * * the trustee * * * disavows the trust, or *holds adversely to the claim of those he represented*." *Bacon* v. *Rives*, 106 U.S. 99, 107 (1882) (emphasis added). Specifically, the Uniform Trust Code provides that the limitations period ordinarily begins to run when the beneficiary receives a report containing an accounting that reveals the existence of a potential claim—by analogy, the point at which an ERISA plan issues its final decision on a benefits claim. Bogert § 965, at 137 (citing

Unif. Trust Code § 1005); see, *e.g.*, Mich. Comp. Laws Ann. § 700.7905 (West 2010); Fla. Stat. Ann. § 736.1008 (West 2008). Permitting ERISA plans to provide a pre-exhaustion limitations-period commencement date would thus be inconsistent with the limitations principles that apply in the trust context and with the constraints on settlors' ability to curtail judicial review.

3. Respondents' proposed case-by-case reasonableness approach would not mitigate the adverse consequences of the plan's limitations provision

Respondents contend that the adverse effects of allowing the statute of limitations to begin running while the claimant pursues internal plan remedies can be addressed by "a case-by-case inquiry into the reasonableness of the limitations period and by application of equitable tolling." Br. in Opp. 23-24; *id.* at 12 (citing cases that endorsed this approach); see *Burke*, 572 F.3d at 81 n.5 (court has authority to determine the reasonableness of and toll limitations period provided in ERISA plan). But the reason that tying the limitations period to proof of loss is inconsistent with ERISA's remedial scheme is that it creates timing uncertainties that distort the parties' incentives and undercut the two-tiered remedial structure. The ad hoc tolling approach respondents advocate would not address that fundamental problem; instead, it would introduce additional uncertainties and result in increased litigation.

Importantly, respondents' case-by-case tolling approach is not a categorical rule that would toll the limitations period during the pendency of plan proceedings in every case. Br. in Opp. 12, 21-22. State courts have sometimes applied a categorical tolling rule to insurance policies that start the limitations period on insurance claims before the conclusion of insurer-imposed prereq-

uisites to suit. See pp. 30-31, *infra*. Unlike that practice under state law, respondents' proposed inquiry would entail an after-the-fact examination of case-specific factors to evaluate whether it would be equitable to enforce the limitations period against a plan participant who brings an untimely claim. Br. in Opp. 12; *Rice* v. *Jefferson Pilot Fin. Ins. Co.*, 578 F.3d 450, 455-456 (6th Cir. 2009). While there presumably would be easy cases at either extreme—where exhaustion either entirely consumed the plaintiff's time to bring suit, or left her with multiple years in the limitations period—the availability of tolling in the many cases between these poles would be considerably less clear. The court would likely have to consider factors such as the amount of time left in the limitations period after exhaustion, the complexity of the plaintiff's claims and the amount of time reasonably necessary to prepare a suit involving those claims, the participant's awareness (or lack thereof) of the running of the limitations period, the diligence with which the participant pursued plan remedies and filed suit, whether the plan was engaged in "a subterfuge to prevent lawsuits," and any other relevant circumstances. *Northlake Reg'l Med. Ctr.* v. *Waffle House Sys. Emp. Benefit Plan*, 160 F.3d 1301, 1304 (11th Cir. 1998); see *White*, 488 F.3d at 259 (Wilkins, C.J., dissenting).

This case-specific approach would leave both parties unable to discern, when the participant initiates her claim, how the limitations period will be enforced in her case. Plans would thus be unable to apprise beneficiaries *ex ante* how much time they will have to file suit and whether an untimely filing might be excused by the courts. See *White*, 488 F.3d at 248-249. That uncertainty is inconsistent with the statutory notice requirements, which are intended to ensure that "every em-

ployee may, on examining the plan documents, determine exactly what his rights and obligations are under the plan." *Curtiss-Wright Corp.*, 514 U.S. at 83 (emphasis omitted); see 29 U.S.C. 1102(a)(1) (requiring plan to be "maintained pursuant to a written instrument").

Given the case-specific nature of the tolling approach, moreover, beneficiaries would have to proceed on the assumption that they will not be entitled to tolling, lest they forfeit their ability to obtain judicial review. The theoretical availability of equitable tolling would therefore not meaningfully alter the perverse incentives created by the pre-exhaustion limitations-period trigger date. Beneficiaries would still be well-advised to expedite the internal process as much as possible. See pp. 22-23, *supra*.

Respondents' rule would also undermine ERISA's objectives by spawning burdensome litigation over the reasonableness of truncated limitations periods, the appropriateness of equitable tolling, and the adequacy of notice. See *Conkright*, 130 S. Ct. at 1649-1650 (discussing ERISA's policy of avoiding "costly litigation"). Given the fact-specific nature of the inquiry, courts would likely come to differing results, even with respect to similarly situated beneficiaries of the same ERISA plan. That is directly contrary to ERISA's goal of fostering "a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 379 (2002).

D. Respondents' Reliance On State Contract Law Is Misplaced

In contending that ERISA plans may provide that the limitations period begins to run well before the

plaintiff may sue, respondents rely on state statutes that permit insurers to insert such provisions in their policies. Br. in Opp. 21-22. Connecticut law, for instance, requires individual disability insurance policies to include a provision stating that an action shall be brought no later than three years after proof of loss must be furnished, and permits group policies to include such a provision. *Ibid.*; see Conn. Gen. Stat. Ann. § 38a-483(a)(11) (West 2010). The existence of such statutes, however, does not suggest that that rule should apply to claims brought under ERISA. State-law rules governing the point at which the statute of limitations begins to run do not apply of their own force to federal causes of action; rather, the courts must decide whether to borrow them as a matter of federal common law. Doing so would be appropriate only if the state-law rule were consistent with the policies animating the federal statute—and that is not the case here.[5] See pp. 16-18, *supra*; see also *Wolfe*, 331 U.S. at 608 (stating that contracting parties may adopt a reasonable limitations period shorter than the "general" period "in the absence of a controlling statute to the contrary").

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[5] Respondent does not contend that, by virtue of the insurance savings clause in ERISA's preemption provision, 29 U.S.C. 1144(b)(2)(A), state law required it to include a provision in its policy that the limitations period begins to run from when proof of loss must be filed. Although the question therefore is not presented here, a state statute that did require such a provision in a plan subject to ERISA would likely be preempted. Cf. *Pilot Life*, 481 U.S. at 52 (explaining that Congress intended to provide an exclusive federal civil enforcement framework for ERISA claims); *Chamber of Commerce* v. *Whiting*, 131 S. Ct. 1968, 1979-1985 (2011) (notwithstanding savings clause preserving certain state laws from express preemption, state law might still be preempted if it conflicted with federal law).

Looking to state laws like Connecticut's for guidance on whether ERISA plans may move up the limitations commencement date would be particularly inappropriate because such statutes are designed to operate in a context that is very different from ERISA: state-law insurance claims, which generally involve no required exhaustion of plan remedies. See *West*, 481 U.S. at 39 (applying state service rule to borrowed state limitations period was inappropriate because "the borrowed statute is to be applied in a context somewhat different from the one in which those [state] procedural rules originated"). A state-law action for benefits allegedly due under an insurance policy is a standard breach-of-contract action adjudicated de novo by the court. See, *e.g.*, *Parrot* v. *Guardian Life Ins. Co.*, 866 A.2d 1273, 1275 (Conn. 2005); *Allstate Ins. Co.* v. *Spinelli*, 443 A.2d 1286, 1292 (Del. 1982). State law generally does not require the plaintiff to have first exhausted any internal remedies the insurer may provide, and the court adjudicates the plaintiff's claim in the first instance, rather than reviewing the insurer's denial of benefits under a deferential standard. See, *e.g.*, *LaPerla, Ltd.* v. *Peerless Ins. Co.*, 980 A.2d 971, 975 (Conn. Super. Ct. 2009). As a result, the plaintiff need not await the conclusion of any internal plan review process before her cause of action accrues. In addition, the contractual nature of the suit reflects the fact that, unlike in the ERISA context, the relationship between insured and insurer is not a fiduciary one based in trust law.[6] See, *e.g.*, *Tucker* v. *State*

[6] The contractual relationship between insured and insurer does implicate an implied duty of fair dealing. A claim for breach of that duty does not accrue until the insurer has unreasonably denied the claim. *Murray* v. *San Jacinto Agency, Inc.*, 800 S.W.2d 826, 829 (Tex. 1990).

Farm Mut. Auto. Ins. Co., 53 P.3d 947, 951-952 (Utah 2002).

Some policies, like Hartford's, provide a waiting period (usually 60 or 90 days after proof of loss is due) during which the insured may not file suit. See Lee R. Russ, *Couch on Insurance 3d* § 236:167, at 236-133 (2000) (*Couch*); Br. in Opp. 3. But after the conclusion of that period, the insured may sue, whether or not the insurer has responded to her demand for payment. See, *e.g.*, *Terry* v. *UNUM Life Ins. Co.*, 394 F.3d 108, 110 (2d Cir. 2005) (per curiam). Thus, although the cause of action may not accrue until the conclusion of the waiting period, see *Millstone* v. *St. Paul Travelers*, 962 A.2d 432, 439 (Md. Ct. Spec. App. 2008), which is after the limitations period has begun to run, the date on which the plaintiff may file her state-law suit does not depend on any action by the insurer. Uncoupling the commencement of the limitations period from the accrual of the claim therefore does not create the uncertainty and conflicting incentives that it does in the ERISA context. In addition, the purpose of state laws permitting insurers to provide a shortened limitations period that runs from the date of proof of loss—to give the insurer certainty about the time for suit and extent of its exposure, and to guard against false claims, *Prudential-LMI Commercial Ins.* v. *Superior Court*, 798 P.2d 1230, 1241-1242 (Cal. 1990)—is already served in the ERISA context by the exhaustion requirement, which provides the plan administrator with notice of the claim and an opportunity to investigate and compile a record.

Moreover, state courts have often refused to apply policy provisions purporting to govern the commencement of the limitations period in a way that allows much of the limitations period to run before the plaintiff can

file suit. Thus, some courts have held that the limitations period should be tolled in all cases during the waiting period, and others have treated the limitations period as beginning to run at the conclusion of the waiting period. See *Couch* § 236:173, at 236-138 to 236-139 & n.55 (citing cases). In addition, when an insurance policy, instead of providing a waiting period, requires an insured to exhaust certain non-judicial procedures, some courts have held that the limitations period is always tolled during the pendency of those proceedings. See, *e.g.*, *Prudential-LMI Commercial Ins.*, 798 P.2d at 1241 (applying tolling where policy provided that limitations period began to run before insured filed notice of claim, and stating that "the purpose of a shortened limitation period was to obtain the advantage of an early trial of the matters in dispute * * * not to achieve a technical forfeiture of the insured's rights"); *Peloso* v. *Hartford Fire Ins. Co.*, 267 A.2d 498 (N.J. 1970); *Couch* §§ 236:6-236:7, at 236-19 ("it would be unconscionable to permit the time for suit to be consumed in pursuing the specified remedies"); but cf. *Boyce* v. *Allstate Ins. Co.*, No. CV 90-0374599, 1994 WL 9956 (Conn. Super. Ct. 1994) (rejecting equitable tolling where limitations period and 60-day waiting period were provided by statute, but holding that equitable estoppel was available if insurer's investigation consumed limitations period).

Thus, if respondents were correct that state laws permitting insurers to uncouple the limitations period from the point at which the plaintiff is able to sue should be adopted as the federal rule for ERISA claims, there would be a substantial argument that under many States' tolling rules, the limitations period should be tolled—in all cases, not only "rare" cases, as respondents propose (Br. in Opp. 25)—while the plaintiff ex-

hausts the plan's internal review procedures. See *Hardin*, 490 U.S. at 539 (if consistent with the federal statute, state tolling rules ordinarily apply to a borrowed state limitations period). Given that tolling principles are designed to mitigate limitations rules that would be unduly harsh in particular circumstances, the need to toll the limitations period in every case under respondents' approach reinforces the conclusion that plans should not be permitted to deviate from the general federal rule, applicable to ERISA, that the limitations period begins to run when the plan issues its final decision.

CONCLUSION

The judgment of the court of appeal should be reversed.

Respectfully submitted.

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