

2020 WL 7315466

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United States District Court, C.D. California.

RAMONA REED, Plaintiff,

v.

GEP ADMINISTRATIVE SERVICES,

INC. EMPLOYEE STOCK

OWNERSHIP PLAN, Defendant.

Case No. 19-cv-9854 DDP (SSx)

|
Filed 12/04/2020

**ORDER DENYING DEFENDANT'S MOTION
FOR SUMMARY JUDGMENT, OR IN THE
ALTERNATIVE, PARTIAL SUMMARY JUDGMENT**

DEAN D. PREGERSON UNITED STATES DISTRICT
JUDGE

*1 Presently before the court is Defendant's Motion for Summary Judgment, or in the alternative, Partial Summary Judgment. (Dkt. 17, MSJ.) Having considered the parties' submissions and heard oral argument, the court denies the motion and adopts the following order.

I. BACKGROUND

Plaintiff Ramona Reed ("Plaintiff") filed this action against Defendant GEP Administrative Services Inc. Employee Stock Ownership Plan ("Defendant") seeking benefits "under the terms of the GEP Plan, an employee benefit plan regulated and governed under [the Employee Retirement Income Security Act of 1974 ("ERISA")]. (Dkt. 1, Compl. ¶ 5.) Plaintiff "was and currently is an employee of GEP Administrative Services, Inc. ('GEP'), a Delaware corporation with its principal place of business in Burbank, California, within the Central District of California." (*Id.* ¶ 7.) "GEP provides administrative support to companies that produce films or television shows, by acting as the employer of record for persons hired by the production company." (*Id.* ¶ 10.)

In 2004, GEP's board of directors adopted the Employee Stock Ownership ("ESOP") Plan ("the Plan").¹ (Dkt. 17-2, Hanson Decl., Ex. A ("AR")² at 110.) Under the Plan, an

employee was an "Eligible Participant," eligible to share in the allocation of employer contributions and forfeitures for a Plan year, if the employee was employed by the GEP at any time during the Plan year and satisfied certain requirements. (*Id.* at 151-52.) The only requirement relevant here, Section 4.3(a), required that an employee complete 1,000 hours of service and be employed with GEP on the last day of the Plan year. (*Id.* at 152.) GEP employed Plaintiff from 1989 to 2004. (*Id.* at 10.) In December 2004, Plaintiff submitted a resignation letter to GEP dated December 10, 2004 stating, in relevant part: "[T]his letter is to announce my resignation with [GEP], starting today. My last day will be December 30, 2004." (*Id.* at 67.)

On November 7, 2006, Plaintiff was re-employed by GEP. (*Id.* at 10.) After Reed completed an hour of service in November 2006, she re-entered the Plan as a participant. (*Id.* at 10.) On September 7, 2007, Plaintiff sent an email entitled "ESOP Question" to Michael Wofford ("Wofford"), the Executive Vice President/General Counsel of GEP. (*Id.* at 100, 105.) The email reads in full as follows:

Good Morning Young Man,

I am getting conflicting info ... I hope you can clear up ...

After 15 years, my last day was December 31st 2004. I returned on Nov. 7, 2006.

Was my ESOP interrupted?

Did I start over?

Thank you

Warmest Regards

Ramona Reed

(*Id.* at 100.) Wofford forwarded the email to Defendant's outside litigation counsel requesting counsel's "thoughts" regarding the matter. (*Id.* at 101.) On September 10, 2007, Defendant's outside counsel responded, amongst other things: "I recommend that we treat this inquiry as a request for benefits and a benefits claim denial. We need to make sure we observe the claims review procedures and inform [Plaintiff] of her right to appeal the adverse decision" (*Id.* at 99.)

*2 On October 5, 2007, Plaintiff received a "formal response to your inquiry" letter via email and U.S. Mail on behalf of the ESOP Committee stating, in part: "You requested clarification of your Plan Account balance and vesting status," and, "[t]he

ESOP Committee has *treated your inquiry* as a claim for benefits under the Plan.” (*Id.* at 105-08 (“Letter of Denial”) (emphasis added).) The Letter of Denial informed Plaintiff that “pursuant to the terms of [Plaintiff’s] resignation letter,” Plaintiff’s last day of employment was December 30, 2004, not December 31, 2004, and as such, Plaintiff did not meet the requirement that she be employed on the last day of the Plan year. (*Id.*) The Letter of Denial also informed Plaintiff that she had the right to appeal within 60 days of the date of the letter. (*Id.*) Plaintiff took no action in response to the Letter of Denial.

On April 30, 2019, through counsel, Plaintiff submitted a formal claim for benefits under the Plan. (*Id.* at 42-43.) On May 31, 2019, Defendant denied Plaintiff’s claim for benefits. (*Id.* at 9.) On August 24, 2019, Plaintiff appealed the denial of benefits according to the terms of the Plan. (*Id.* at 44-48.) On appeal, Plaintiff declared that she wrote her resignation letter designating December 30, 2004 as her last day because she “knew December 31, 2004 was a companywide holiday and no one would be working that day.” (*Id.* at 60, ¶ 13.) On November 8, 2019, Defendant denied Plaintiff’s appeal. (*Id.* at 36-41.) On November 18, 2019, Plaintiff filed this action asserting that Defendant wrongfully denied her claim for benefits by incorrectly concluding that she was not employed on December 31, 2004. (*See* Dkt. 1, Compl.)

Defendant presently moves for summary judgment contending that Plaintiff’s claim is time-barred by the four-year statute of limitations because, according to Defendant, Plaintiff’s November 2007 email constituted a “claim for benefits” which became a final denial when Plaintiff did not appeal. (MSJ at 7-12.) Defendant also moves for summary judgment based on laches, waiver, and estoppel. (*See* MSJ.) Alternatively, Defendant moves for a partial summary judgment ruling that “(1) Defendant’s denial of [Plaintiff’s] claim for benefits should be reviewed for an abuse of discretion; and (2) that the Court’s review of Defendant’s decision to deny [Plaintiff’s] claim for benefits should be limited to the administrative record.” (*Id.* at 1:22-25.)

II. LEGAL STANDARD

Summary judgment is appropriate where the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show “that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.” *Fed. R. Civ. P.* 56(a). A party seeking summary judgment bears the initial burden of informing the court of the basis for its motion and

of identifying those portions of the pleadings and discovery responses that demonstrate the absence of a genuine issue of material fact. *See*  *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). All reasonable inferences from the evidence must be drawn in favor of the nonmoving party. *See*  *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 242 (1986).

“In the ERISA context, a motion for summary judgment is merely the conduit to bring the legal question before the district court and the usual tests of summary judgment, such as whether a genuine dispute of material fact exists, do not apply.  *Harlick v. Blue Shield of California*, 686 F.3d 699, 706 (9th Cir. 2012) (quotations and citation omitted).

III. DISCUSSION

1. Statute of Limitations

Because there is no federal statute of limitations governing ERISA benefit claims, federal courts look to the state’s most analogous statute of limitations.  *Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Ins. Program*, 222 F.3d 643, 646-47 (9th Cir. 2000) (en banc). In *Wetzel*, the Ninth Circuit held that in California, the most analogous statute of limitations is [Section 337 of the California Code of Civil Procedure](#) providing a four-year statute of limitations.

 *Id.* at 649. Although state law determines the relevant limitations period for a benefit claim, federal law determines when a claim for relief accrues. *See, e.g.,*  *Wise v. Verizon Commc’ns, Inc.*, 600 F.3d 1180, 1188 (9th Cir. 2010). “[A]n ERISA cause of action” based on a claim for benefits “accrues either at the time benefits are actually denied, or when the insured has reason to know that the claim has been denied.”

 *Wetzel*, 222 F.3d at 649 (internal citation omitted). Thus, an ERISA benefits claim in California must be filed within four years of the date the claim was actually denied or the date when the insured had reason to know that the claim was denied. *Id.*

*3 Defendant contends that, under the first prong of the accrual test, Plaintiff’s September 7, 2007 email to Wofford constituted a “claim for benefits” that was “actually denied” when Plaintiff failed to appeal the denial. According to Defendant, Plaintiff “asked about her status under the Plan,” “took the position that her last day of employment was

December 31, 2004,” and “the substance of [Plaintiff’s] email was a request for Defendant to restore forfeitures attributable to the 2004 Plan year.” (MSJ at 9:1-8 (emphasis added).) Under Defendant’s interpretation, Defendant’s October 5, 2007 Letter of Denial was a denial of benefits that became final when Plaintiff failed to appeal the denial within 60 days of the Letter of Denial. (MSJ at 7-12.)

Under ERISA regulations, a “claim for benefits” is defined as follows: “For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan’s reasonable procedure for filing benefit claims.” (emphasis added)). It is clear from Plaintiff’s September 7, 2007 email, that Plaintiff did not request that Defendant restore forfeitures under the Plan—Plaintiff merely asked for information about her status under the Plan. Specifically, Plaintiff asked for two pieces of information, (1) was her ESOP interrupted, and (2) did she “start over.” (AR at 100 (“Subject: ESOP Question”; “I am getting conflicting info ... I hope you can clear up ... After 15 years, my last day was December 31st 2004. I returned on Nov. 7, 2006. Was my ESOP interrupted? Did I start over?”). No reasonable reading of Plaintiff’s email suggests that Plaintiff was requesting Plan benefits at that time. Indeed, the express language in the email reveals that Plaintiff did not know whether she had any contributions or forfeitures in 2004. *Id.* (“Was my ESOP interrupted?”). The mere fact that Defendant would necessarily respond to Plaintiff’s inquiry with information regarding Plaintiff’s ESOP account, such as informing Plaintiff that her ESOP was interrupted and that her ESOP account did start over, did not convert Plaintiff’s inquiry into a request for plan benefits.

Moreover, under the Plan, a person who wishes to make a claim for benefits must do so in writing and the writing must be signed by the claimant or an authorized representative. (AR at 184, § 9.10 (“Claims Procedure, (a) “Filing Claim for Benefits”: ... All claims must be made in writing and *must be signed* by the Claimant or an authorized representative.”.) The parties do not appear to dispute that Plaintiff did not submit a signed writing as required by the Plan. It appears that Defendant unilaterally decided to treat Plaintiff’s inquiry as a request for plan benefits. (AR at 99 (“I recommend that we *treat this inquiry* as a request for benefits and a benefits claim denial.” (emphasis added)); AR at 105-08 (“The ESOP Committee has *treated your inquiry* as a claim for benefits” (emphasis added).) Defendant argues that it was required to treat Plaintiff’s email as a claim for benefits because the “email potentially impacted the account balances

of all of the other participants of the Plan.” (Mot. at 9; Reply at 3-4.) Such a conclusion is erroneous. Plaintiff only asked for information. The account balances of other participants at that time were not potentially impacted. Had Plaintiff made an actual claim for benefits, a request for contributions for 2004, then account balances could have potentially been impacted. In any event, potential impact on other participants’ accounts is not relevant to whether Plaintiff made a claim for benefits. Defendant’s decision to *treat* Plaintiff’s inquiry as a claim for benefits does not make it so. The court’s reading of Plaintiff’s email is consistent with ERISA regulations. See 29 C.F.R. § 2560.503-1. Plaintiff requested information regarding her status and did so in an email—not in a writing signed by Plaintiff or her authorized representative.

*4 The court concludes that Plaintiff did not make a claim for benefits under the Plan. Defendant’s Letter of Denial was premature and could not be an actual denial of a claim for benefits. Plaintiff’s ERISA cause of action did not accrue under the first prong of the accrual test.³

Next, Defendant argues that the annual benefits statements Plaintiff received each year from 2007 to 2019 were “a clear and continuing repudiation” of Plaintiff’s rights such that Plaintiff’s claim is also barred under the second prong of the accrual test. (*Id.* at 10 n.5; Reply at 6-7.) “[A] cause of action accrues when a pension plan communicates ‘a clear and continuing repudiation’ of a claimant’s rights under a plan, such that the claimant could not have reasonably believed but that his [or her] benefits had been ‘finally denied.’”  *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1031 (9th Cir. 2006) (quoting  *Wetzel*, 222 F.3d at 650)). However, the Administrative Record does not contain any annual benefits statements nor have these statements otherwise been provided to the court. Therefore, the court declines to grant summary judgment under the second prong of the accrual test.

2. Laches, Waiver, Estoppel

Defendant next argues that Plaintiff’s action is barred by laches because Plaintiff “had actual knowledge as early as 2007 that she could file a cause of action under ERISA, and her delay of over 11 years is unreasonable and inexcusable” (Reply at 7.) Defendant asserts that it is prejudiced because “it would have to undergo the burdensome task of recalculating benefits for Reed and all of the other

participants in the Plan due to Reed's unreasonable and inexcusable delay.” (*Id.* at 14.)

“Laches is an equitable time limitation on a party's right to bring suit, resting on the maxim that one who seeks the help of a court of equity must not sleep on his rights.”  *Jarrow Formulas, Inc. v. Nutrition Now, Inc.*, 304 F.3d 829, 835 (9th Cir. 2002) (citations omitted). “To prove laches, the defendant must prove both an unreasonable delay by the plaintiff and prejudice to itself.” *Evergreen Safety Council v. RSA Network Inc.*, 697 F.3d 1221, 1226 (9th Cir. 2012) (citations omitted); see also *Otto v. Emp. Ret. Income Plan – Hourly W.*, 2015 WL 12516690, at *9 (C.D. Cal. Mar. 13, 2015) *aff'd sub nom. Otto v. Employee Ret. Income Plan*, 667 F. App'x 660 (9th Cir. 2016) (in the ERISA context, a defendant asserting the defense of laches must show “inexcusable delay in the assertion of a known right, and prejudice to the defendant”). If a claim “is filed within the analogous state limitations period, the strong presumption is that laches is inapplicable”

 *Jarrow*, 304 F.3d at 837.

As discussed above, Plaintiff filed this action within the limitations period, therefore, there is no presumption of laches. Assuming without deciding that Plaintiff should have known of the cause of action in 2007, Defendant nonetheless has failed to establish prejudice to itself. Defendant does not sufficiently explain nor present any evidence as to how the alleged “burdensome” task of recalculating benefits will cause any harm. The court declines to dismiss Plaintiff's action based on laches.

*5 Similarly, the court concludes that Defendant has not demonstrated that Plaintiff waived her right to bring a cause of action. Defendant largely relies on the Letter of Denial to argue that Plaintiff knew or should have known of her right to bring a cause of action in 2007 and did not do so until eleven years later. “A waiver may be implied upon a showing that a party's acts are so inconsistent with an intent to enforce the right as to induce a reasonable belief that such right has been relinquished.” *Burdick v. Union Sec. Ins. Co.*, No. CV 07-4028 ABC (JCX), 2009 WL 6541608, at *11 (C.D. Cal. Apr. 2, 2009). “The party raising waiver has the burden of establishing it at trial by clear and convincing evidence that does not leave the matter to speculation, and doubtful cases will be decided against a waiver.” *Id.* As discussed in detail above, in 2007, Plaintiff sought clarifying information—Plaintiff did not make a claim for benefits at that time. In context, Plaintiff's silence after receiving the

requested information is not “clear and convincing” evidence that Plaintiff intended to relinquish her right to make a future claim for benefits under the Plan.

Lastly, Defendant also argues that Plaintiff is estopped from claiming benefits under the Plan based on Plaintiff's silence. For estoppel to apply, “1) the party to be estopped must be apprised of the facts; 2) the other party must be ignorant of the true state of facts, and the party to be estopped must have acted so that the other party had a right to believe that the party intended its conduct to be acted upon; and 3) the other party relied on the conduct to its prejudice.”  *LaMantia v. Voluntary Plan Administrators, Inc.*, 401 F.3d 1114, 1119 (9th Cir. 2005). As an initial matter, the court is not aware of any cases in which a party has been estopped from claiming ERISA benefits when that party has filed an action within the statute of limitations. Even if estoppel could be asserted here, under the circumstances of this case, Defendant has failed to demonstrate that Defendant had a right to believe Plaintiff would not make a claim for benefits in the future. Defendant ostensibly attempted to force Plaintiff into the process of claiming benefits in 2007 by *treating* Plaintiff's inquiry as a claim for benefits. Based on its own action, Defendant now seeks to preclude Plaintiff from pursuing her right to claim benefits under the Plan. Defendant's purported reliance on Plaintiff's silence, however, cannot be attributed to Plaintiff's conduct. The court denies summary judgment based on estoppel.

3. Standard of Review and Review is Limited to the Administrative Record

Defendant moves for a ruling that the court's review of Defendant's adverse benefits determination will be reviewed by the court under an abuse of discretion standard and will be limited to the Administrative Record. (Mot. at 15-16.) A district court reviews under an abuse of discretion standard “whenever an ERISA plan grants discretion to the plan administrator, but a review [is also] informed by the nature, extent, and effect on the decision-making process of any conflict of interest that may appear in the record.”  *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967 (9th Cir. 2006). “The district court may, in its discretion, consider evidence outside the administrative record to decide the nature, extent, and effect on the decision-making process of any conflict of interest; the decision on the merits, though, must rest on

the administrative record once the conflict (if any) has been established, by extrinsic evidence or otherwise.”  *Id.* at 970.

Plaintiff does not dispute that the Plan grants discretion to the plan administrator. (*See* Opp. at 16-20.) Plaintiff argues, however, that she “intend[s] to present evidence showing the GEP Plan was conflicted and that this conflict impacted its decision-making process.” (*Id.* at 25:10-13.) Because the parties have insufficiently addressed the issues of conflict of interest and the effect on the decision-making process in the present motion, the court denies the motion without prejudice. The court will address these issues at trial.

IV. CONCLUSION

***6** The court denies Defendant's motion for summary judgment based on statute of limitations, laches, waiver, and estoppel.

The court denies without prejudice Defendant's motion for a ruling that the court will review the adverse benefits decision under an abuse of discretion standard and that its review will be limited to the Administrative Record.

IT IS SO ORDERED.

All Citations

Slip Copy, 2020 WL 7315466

Footnotes

- 1** In March 2019, GEP entered into a stock purchase agreement that resulted in the Plan selling all outstanding stock, and shortly thereafter, on March 31, 2019, the Plan terminated. (*Id.* at 11, 200.)
- 2** Pincites refer to the “GEP_REED_” page number listed on the Administrative Record.
- 3** Because the court concludes that Plaintiff's claim for benefits did not accrue in 2007, the court does not reach the parties' additional arguments of whether the Letter of Denial was a final unambiguous denial letter or whether the Plan's appeal process was voluntary or mandatory. (*See* Mot. at 11-12; Opp. at 13-15.)