PUBLICATION

Court of Appeals to Plan Administrators: Inform Claimants of Time Limits on Front End of Discussions

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Recently, in *Mirza v. Insurance Administrator of Am., Inc.*, the United States Court of Appeals for the Third Circuit was asked to determine whether plan administrators are required to include a description of internal plan deadlines for seeking judicial review of benefit claims denials in benefit denial letters sent to claimants. The *Mirza* decision involved an individual identified only as "N.G." who was a participant in an ERISA-governed health plan maintained by her employer. N.G. sought medical treatment from Dr. Neville Mirza due to severe back pain she was experiencing. In connection with the medical treatment, N.G. assigned her right to benefits under the health plan to Dr. Mirza. Thereafter, Dr. Mirza performed a surgical procedure on N.G. and submitted a claim of $34,500 to Insurance Administrator of America, Inc. (IAA), the claims administrator for the health plan.

IAA initially denied Dr. Mirza's benefit claim on June 2, 2010, on the basis that Dr. Mirza had not submitted sufficient documentation in support of his claim. Dr. Mirza submitted the requested documentation. Eventually, on August 12, 2010, IAA issued its final denial of Dr. Mirza's claim, concluding that the surgical procedure performed by Dr. Mirza on N.G. was medically investigatory and, therefore, not covered by the health plan. At the end of the final denial letter, IAA informed Dr. Mirza that he had the "right to bring a civil action under ERISA § 502(a)" if he disagreed with its final determination. Nowhere in that letter, or in any prior correspondence from IAA, did IAA inform Dr. Mirza that the health plan required Dr. Mirza to seek judicial review of IAA's final benefit denial within one year of the date of that denial, a time period known as the "Plan Limitations Period". Thereafter, Dr. Mirza retained the law firm of Callagy Law to represent him in connection with his benefit claim.

Around the same time that N.G. visited Dr. Mirza, she also visited and assigned her rights under the health plan to Spine Orthopedics Sports (SOS). SOS treated N.G. and submitted a claim to IAA, which made only partial payment to SOS. SOS, like Dr. Mirza, hired Callagy Law to represent it in connection with its benefit claim under the health plan. On November 23, 2010, an employee of Callagy Law spoke on the phone with an employee of IAA, who claimed to have read verbatim the health plan language regarding the Plan Limitations Period. Thereafter, on April 22, 2011, Callagy Law received a copy of the health plan documents, which constituted the first instance in which Callagy Law and Dr. Mirza received written notice of the Plan Limitations Period. Then, on March 8, 2012 – some 19 months after Dr. Mirza received the August 12, 2010, denial of his claim for benefits – Dr. Mirza initiated a lawsuit against IAA for unpaid benefits.

The district court granted summary judgment in favor of IAA, concluding that: (1) the Plan Limitations Period was reasonable; (2) absent a basis for equitable tolling, Dr. Mirza's lawsuit was time-barred because it was filed more than one year after the final denial of his benefit claim by IAA; and (3) Dr. Mirza had knowledge of the Plan Limitations Period by virtue of Callagy Law becoming aware of it either orally on November 23, 2010, or in writing on April 11, 2011, both of which dates fell within the one-year deadline for initiation of Dr. Mirza's lawsuit.

The Third Circuit rejected the district court's approach, focusing instead on IAA's regulatory obligations when advising a claimant of a benefit denial. Citing the ERISA benefits regulations codified at 29 C.F.R. § 2560.503-1, the Third Circuit concluded that IAA, when communicating the denial of Dr. Mirza's benefit claim, was

obligated to set forth "a description of the plan's review procedures and the time limits applicable to such procedures[.]" The Third Circuit found that this obligation applied not only to time limits for internal plan appeals, but also to plan-imposed limits placed on a claimant's right to bring an action for judicial review of a benefit claim denial. It further held that the failure by IAA to include a description of the Plan Limitations Period in its final benefit denial letter meant that letter was not in substantial compliance with the ERISA benefits regulations. For that reason, the Third Circuit decided that the proper remedy would be to set aside the Plan Limitations Period. In substitution for the Plan Limitations Period, the Third Circuit applied New Jersey's six-year statute of limitations for breach of contract actions, which it concluded was the limitations period for the state law claim most closely analogous to an ERISA claim for benefits. The application of the six-year limitations period rendered Dr. Mirza's lawsuit timely.

In light of the Third Circuit's decision in *Mirza*, entities charged with deciding benefit claims and communicating benefit denials should consider reviewing their procedures and form communications to ensure that plan-imposed time limitations for seeking judicial review of benefit denials are clearly and expressly communicated to claimants whose benefit claims have been denied.