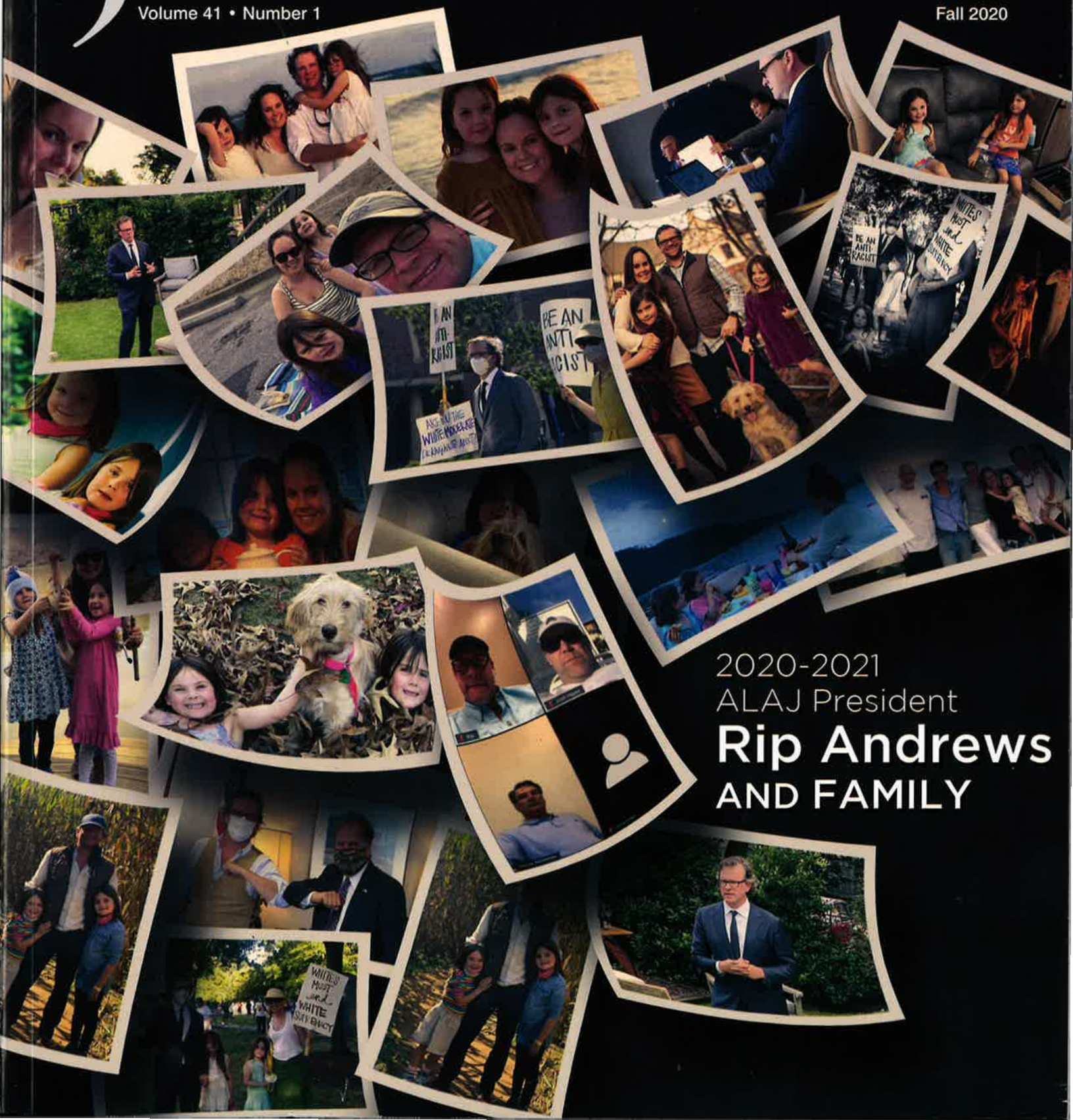
ALABAMA ASSOCIATION FOR JUSTICE

# JOURNAL

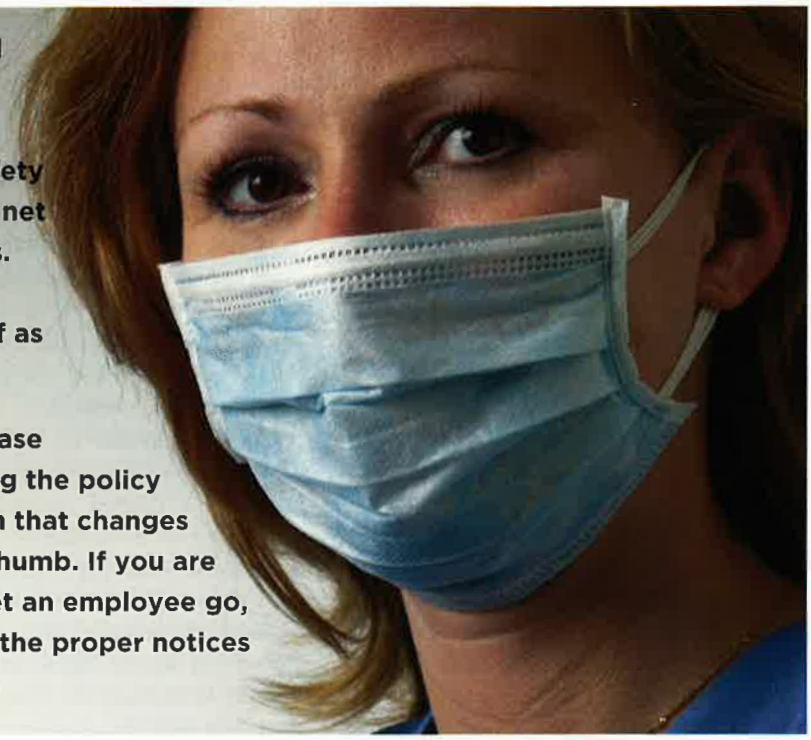
Volume 41 • Number 1

Fall 2020




2020-2021
ALAJ President
**Rip Andrews**
**AND FAMILY**

# Disability, Life and Health Insurance in the Age of Covid



**The COVID-19 panic has upended and changed almost every aspect of our interactions and daily lives, and insurance is no different. Given insurance's primary purpose is to provide a safety net when the unthinkable happens, that safety net is of vital importance during these trying times. The purpose of this article is to briefly set out some of the things that you should be aware of as practitioners, insureds, and employers.**

**If you take anything away from this article, please remember that the essential first step is reading the policy and plan documents because there is too much that changes between policies to provide any true rules of thumb. If you are in the unfortunate circumstance of having to let an employee go, then it is also vital that you provide them with the proper notices concerning their benefit elections and options.**

## Employee Retirement Income Security Act (ERISA)[1] and Disability

The pandemic has done little to change the fact that ERISA is a complicated headache, but the Department of Labor and Internal Revenue Service have instituted some changes to assist with the many difficulties currently facing insureds.[2]

As we have written previously, ERISA's deadlines are extremely important and a misstep can result in closing the courthouse doors permanently for the insured or client.[3] Similarly, if litigation is necessary, you will not typically be able to rely on any evidence that was not submitted to the insurance company during its claims handling prior to the insurer's final decision.

There are a lot of deadlines that can change based upon the type of claim, who is making the decision, and a number of other factors. To simplify things, this article will use the 180-day appeal deadline that most commonly applies to group insurance health, life and disability claims to establish a baseline for discussing the COVID-19 changes. However, please be aware that the deadline could be **far shorter** in many situations.[4] Also, please know that many insurers will take the opportunity to snap the record shut as soon as they receive a communication after their denial, so be sure to put in every letter that more information will be forthcoming and that the insurer's own decision deadlines have not yet begun.[5]

Normally, a claimant will have 180 days to appeal after receiving a denial letter. Due to the COVID-19 pandemic, the Department of Labor has effectively tolled all portions of this deadline that fall between March 1, 2020 through sixty (60) days after either 1) the announced end of the National Emergency[6] or 2) such other date announced by the Department in a future notice. That end date is referred to as the end of the "Outbreak Period" and has not yet been announced, and there are no current predictions for when it will come. ERISA practitioners are obviously hoping there will be advance notice and some guidance prior to that time.[7]

While this is certainly a welcome and necessary measure, it does not mean we can delay anything or that we will actually have any "extra" time. COVID-19 makes everything take longer, even the most routine tasks. To complicate things further, some insurers *appear* to be attempting to use the pandemic to their advantage. For instance, some insurers are still attempting to impose arbitrary deadlines for receipt of doctor's records, but obtaining these records (or even getting an appointment) is often far more difficult than in pre-pandemic times. Some insurers are even going as far as pointing to this sporadic medical treatment as evidence that an insured is not truly impaired. It is important to obtain an up-to-date list of all providers very early on because it is not unusual for it to take months to obtain the client's medical records, even with persistence.

Although many of the insurers' claims personnel were already working remotely and were able to transition to COVID-19's "new normal" relatively painlessly, several of the major insurers still seem to be in disarray 8 months later. This has resulted in lost communications to and from our office, extreme delays, and a large number of other problems that are concerning. Given many of these irregularities could potentially be used against the insured (e.g. manufacture of a "reasonable basis" for a denial of benefits), the COVID extensions do not change the fact that we are now in a situation where we must be more vigilant than

before. When dealing with insurers right now, it is a good practice to send important communications simultaneously in multiple forms (e.g. fax, e-mail, and certified mail) to ensure they are received and responded to in a timely manner.

While the Department of Labor's extensions had to happen, they have also come with the unavoidable consequence that insureds are left languishing without their financial safety net for that much longer. While it is a best practice to pretend the prior deadlines still exist, it is a grave mistake to finalize the appeal before all supporting evidence is obtained and submitted. This creates something of a tightrope because even one extra month without income can be too much for many insureds. As practitioners of every kind are likely aware, the Department of Labor's COVID-19 tolling is not the only cause of delay for ERISA claims. Progression in civil litigation has significantly slowed across the board, so this too must be taken into account

Finally, it is also very important to keep in mind that the statute of limitations varies significantly from plan to plan. While this date most commonly begins on the date the Plan issues its appeal denial, it does not always do so. If the limitations period begins before the appeal deadline or if you engage in the voluntary second appeal that some plans offer, you cannot simply assume the statute has been tolled due to the extra COVID-19 time. Thankfully, the DOL's 2018 rule changes require insurers to clarify these issues. If there is any doubt, please make sure to send them a written request for an explanation of when the statute of limitations begins and when it would end.[8] Although the ratios certainly seem to vary from company to company, there are some good people who work for insurance companies, and you may be surprised to find that some of them will be willing to help with extensions or any other accommodations or concerns you may have.

## Questions Pertaining to Disability Claims in General

Many of the questions raised by COVID-19 apply both to Individual Disability Insurance (IDI) and ERISA-governed claims. I will briefly run through some of the more glaring questions that you should be aware of before filing a claim of either kind.

As an example, IDI and essentially all ERISA-governed disability insurance benefits typically have some sort of "active at work" provisions that require the claimant to presently be working to qualify for coverage. Many policies go so far as to require the insured be working "full time" or at a minimum thirty (30) hours a week in order to qualify for coverage. What does this mean when an insured's hours have been cut due to the pandemic? If cuts were company-wide, are any of the employees actually receiving disability coverage during this time when premiums are presumably being paid? Has this temporarily modified what "full-time" is? It is frankly naïve to think that most insurers will resolve these types of questions in favor of the insured, and it is unlikely the policy was drafted with this kind of event in mind. This is particularly important to know regarding your own hours and when addressing any insurance questions your employees may ask.

Similarly, it is a go-to tactic for insurers to define a job's physical requirements as minimally as possible, and to then find that the insured is not disabled because they can perform those minimal requirements.[9] Given the way many occupations have had to change, we expect to see a number of denials that are based on these "new" definitions of the insured's position. It will be important to head off these issues and document that any such changes are temporary and do not change the character of the insured's occupation.

Many disability policies are drafted in a way that require objective evidence of the level of an insured's limitations and restrictions. Even in the absence of such policy language, insurers and their paid medical reviewers will often try to assert the lack of objective evidence as a basis for denial. Given a large chunk of conditions simply do have universally accepted "objective" means for documenting impairment, this has long been a point of contention. In such situations, an independent medical examination ("IME") with some type of functional capacity assessment will often be the only means for providing objective evidence of your client's impairments.

These examinations are typically lengthy affairs, and some of them can last several full days. Needless to say, COVID-19 has made obtaining these harder for many insureds, and there may be risks to performing such an examination, particularly if the insured is immunosuppressed. This has led to insurers increasingly citing the lack of an IME or other objective evidence when denying claims, and it has also led to them using pure paper reviews by physicians as a substitute when they would normally need to obtain an IME in cases involving close calls. It is important to know what your client can or cannot do regarding IMEs and to plan accordingly from the outset.

## Disabilities Due to COVID-19

Despite the rapid medical advancements that have been made in the past century, it is still fairly common for doctors to be unable to explain the cause of an insured's ailments and impairments. We often see a client spending months or years bouncing around to different specialists just to rule out causes and narrow the list of possibilities. Some people never get a definitive answer, and they just have to continue on without any explanation.

Even when the insured's treating physicians confirm that the patient is impaired, insurers and their pure paper medical reviewers will often treat the lack of a specific diagnosis as meaning the insured is either malingering or a hypochondriac. This was problematic before the pandemic, and we expect things to get worse with COVID-19. We are likely years from conclusively determining what parts of the body are damaged by COVID-19 and for how long. Currently, scientists believe it can attack the respiratory system, the circulatory system, the heart, the brain and nervous system, the renal system, the liver, and the gastrointestinal system.[10] Given how long it takes to research and understand the interplay of medical conditions, it will likely be years or decades before from understanding its long-term impact with certain co-morbid conditions.

While most COVID-19 patients recover within 2 to 8 weeks, a large percentage of patients report persistence of one or two symptoms a few months after the virus has been cleared. More troublingly, a small yet significant percentage of patients report indefinite persistence of symptoms such as extreme fatigue, cognitive deficits, pain, breathlessness, and headaches.[11] This are a number of terms used to reference these patients, but "long-haulers,"[12] "long-COVID,"[13] and "Post COVID-19 Syndrome"[14] are the most prevalent. History does not indicate disability insurers will treat long haulers favorably or fairly once they begin making claims.

## Life Insurance Considerations

When it comes to one of the most important "safety net" coverages, life insurance, you have many of the same considerations in place as you do when discussing disability insurance. Many of the group life insurance plans offered through employers contain the same "active at work" requirements, meaning that in order to qualify for coverage, you must be working a certain number of minimum hours per week. This is also problematic in the current age with layoffs and furloughs given insurers can argue people who were not actively at work did not qualify for coverage, regardless of whether or not the premiums were paid on their life insurance.

Both group and individual life insurance policies come with an additional consideration: it's possible the life insurance coverage may contain a "waiver of premium benefit," which will provide continued life coverage at no cost if the insured is found to be disabled. One recent example involved an insured who became ill and could not return to work but failed to file a disability claim with the life insurance carrier. Unfortunately, the illness resulted in death and his family was left wondering why the life insurance did not pay. The answer from the carrier was that he was not actively at work for several months before his death and, therefore, did not qualify for the coverage. His coverage would have continued and all premiums would have been waived for any period of disability, so this result was unnecessary.

When the life insurance policy contains a waiver of premium benefit as a result of disability, it needs to be triggered as quickly as possible in the event the worst happens. This is especially true when you are talking about COVID-related illnesses which could potentially lead to disabilities and those disabilities would, absent a claim for waiver of premium and a disability claim being filed with the life insurance company, lead to the lapse of the life insurance coverage due to the failure to meet the active-at-work requirement.

## Impact on Health Insurance and HIPAA, COBRA, and CHIP

The COVID-19 changes discussed above also tolled the following periods during the National Emergency: COBRA elections, special enrollment requests, COBRA payment deadlines, qualifying event notifications, and notice of claims.[15]

These changes mean insureds now have much longer to make these elections or bring notice of a claim. As an example, employees would typically only have 30 days[16] to enroll in a health plan or to add a new dependent due to certain special events such as marriage, birth, or adoption. Those 30 days will not begin (or resume) decreasing until 60 days after the end of the National Emergency (i.e., the end of the Outbreak Period), as long as any applicable premiums are paid.

The changes to COBRA elections and premium payments are particularly noteworthy. Normally, premium payments are only timely if they are made within 30 days of the date they came due, but the tolling applies here as well. Insurers cannot deny coverage or deny claims made during the Outbreak Period for lack of payment of premiums if any of the 30-day period coincided with the Outbreak Period. The insured will likely be looking at a very large bill at the end of the Outbreak Period, but at least they will not have to forgo any necessary medical care now. As an employer, it is important to ensure that employees are provided with the requisite notice of their conversion rights under COBRA.

## Conclusion

This is only a brief summation of *some* of the "COVID problems" we are seeing in the context of disability, life, and health insurance (and essentially any insurance provided through employers). Given the pressures that are being placed upon health and life insurers, many of them may attempt to offset their losses by taking a more aggressive posture in the claims arena. It is important to be aware of these issues and to make sure your clients are aware of the new hurdles they must clear.

1 29 U.S.C. § 1001, et seq.
2 85 F.R. 26351.
3 Lanfear v. Home Depot, Inc., 536 F.3d 1217 (11th Cir. 2008) (reiterating that exhaustion is required for ERISA claims).
4 Heimeshoff v. Hartford Life & Acc. Ins. Co., 571 U.S. 99, 102 (2013) (Contractual limitations period that began with "proof of loss" rather than "appeal decision" would be enforced as written. Thus, the limitations were running while remedies were being exhausted).
5 Melech v. Life Ins. Co. of N.A., 739 F.3d 663 (11th Cir. 2014).
6 This is a reference to the National Emergency Proclamation issued by the President on March 13, 2020. https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/
7 The Department of Labor's Employee Benefits Security Administration (EBSA) and the Internal Revenue Service (IRS) have published a lot of explanatory materials on this topic that should answer any more specific questions you may have.
8 29 C.F.R. 2560.503-1(j)(4)(iii).
9 Accuracy of the occupational assessment is important. E.g. Shultz v. Aetna Life Ins. Co., 1:16-CV-94-MHT-DAB, 2017 WL 4803806, at *5 (M.D. Ala. July 13, 2017) ("In other words, Aetna, by its own admission, determined that the prior occupation, from which Plaintiff was unquestionably disabled, was the direct equivalent of the "reasonable occupation" Aetna used to terminate those same LTD benefits.").
10 Marie McCullough, Much More than Just the Flu, The Philadelphia Inquirer (Aug. 21, 2020) https://www.inquirer.com/health/coronavirus/ing/coronavirus-symptoms-affects-organs-human-body-20200821.html
11 COVID-19 (coronavirus): Long-term effects, Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-long-term-effects/art-20490351.
12 Rita Rubin, As Their Numbers Grow, COVID-19 "Long Haulers" Stump Experts, The Journal of the American Medical Association (JAMA), (Sept. 23, 2020) doi:10.1001/jama.2020.17709.
13 James Gallagher, 'Long Covid': Why are some people not recovering?, BBC News (Oct. 6, 2020) https://www.bbc.com/news/health-54296223
14 Ray Perrin, Lisa Riste, & Mark Hann, Into the looking glass: Post-viral syndrome post COVID-19, Medical Hypotheses. 2020; 144:110055.
15 85 F.R. 26351.
16 This would be 60 days in the case of special enrollment rights added via the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP).

**Tom Sinclair** is the founding partner of Sinclair Law Firm, LLC ( www.sinclairlawfirm.com ) in Birmingham, Al. Tom has spent two decades helping people obtain their group and individual life, disability, pension and health benefits. He serves as counsel to the physicians, attorneys and other professionals in his community who need assistance in obtaining their private disability insurance benefits. He spends a lot of time handling ERISA claims in litigation and has served as lead class counsel for hundreds of thousands fighting for their pension benefits