COVID-19 and ERISA disability claims

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While state and federal courts and some administrative agencies have been tolling or extending deadlines to address the impact of COVID-19 on litigation, the Department of Labor (DOL) has not yet offered similar relief for the administration of disability claims. Because of current stay at home orders and social distancing requirements, claims administrators may have difficulty obtaining independent medical exams or gathering and reviewing medical records from medical providers to meet DOL deadlines.

Recognizing that the majority of litigation arising under the Employee Retirement Income Security Act (ERISA) stems from long-term disability claims, in 2018, the DOL issued new regulations concerning the disability claims procedure for ERISA-covered employee disability benefit plans. Under the amended rules, if a plan fails to comply with the DOL's deadlines[1] for claim review and determination, a claimant may be deemed to have exhausted their administrative remedies and may choose to initiate litigation. In those circumstances, the court may review the case under the *de novo* standard of review, as opposed to an arbitrary and capricious standard, resulting in less deference to the decision made by the claims administrator.

While it is possible that the DOL and federal courts will consider COVID-19 to be a "matter beyond the control of the plan," warranting an extension of deadlines, plan sponsors and claims administrators should have a plan to address and document processing of claims and communicating with claimants during these uncertain times. Additionally, it is important that employers and claims administrators be aware of and prepare for a potential increase in short- and long-term claims specific to COVID-19 illnesses, as the long-term health impact of the virus is still unknown.

[1] Disability claims must be decided within a reasonable time period but no later than 45 days after the plan receives the claim. This deadline may be extended for two 30-day periods if "necessary due to matters beyond the control of the plan." Disability appeals must be reviewed within a reasonable period of time but no later than 45 days after the plan receives the request to review a denied claim. Current regulations allow the plan administrator to extend the time for an additional 45 days by written notice prior to expiration of the initial 45-day period if the plan administrator determines that special circumstances require such an extension.

Authors