ERISA Advisory Panel:

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Actuarial Background

I have been a Group Insurance actuary since 1992 and have worked at my employer Smith Group since 1999, providing Long-Term-Disability consulting advice to many of the top LTD writers. I have been an active member of the Society of Actuaries (SOA) Group Long Term Disability Experience Committee and performed the hands-on technical development of the current industry standard claim termination reserve tables (GLTD2008 and GLTD2012). Though out my current I have focused on technical data analysis and advice based on strong empirical findings. In this testimony I will try to speak clearly and factually, but to the extent that I offer my opinions, these are my own and do not represent the opinions of either my employer or my client companies.

History and Prevalence of the Mental Nervous benefit limitations

I estimate that more than 99% of all group LTD insurance policies limit the benefit durations for strictly mental health claims. Almost all companies have filed language that allows unlimited coverage for an additional cost, but, I believe, many also have underwriting rules that limit this offering, and this along with the fact that the unlimited provision is expensive, means that it is rarely offered. Less than 1% of all claims in the most recent SOA study are identified as having an unlimited Mental Health limit. The rarity of the provision makes it difficult for carriers to assess the value of the limit, as I will discuss later.

I have been asked on several occasions to provide an actuarial justification for the mental nervous limits. It has not been clear how to demonstrate this and so in the early 2000s I made an effort to understand the origins of the limit by talking to several older actuaries who had been working in the 1970's and 1980's. They indicated that the limits had been in place since the 1960's at least and so were likely part of the original product design. Nor were they able to provide explicit risk-based justifications of the limits, but speculate that due to the subjective nature of many mental health conditions insurance carriers were worried that with these types of illnesses it was too easy to abuse the policy and so the limits were put in place to help control for this particular type of risk.

My opinion is that since that time there has been a significant broadening of our understanding of what types of conditions constitute a legitimate disability, so that now we commonly include conditions such as chronic pain, including back pain and carpal tunnel, as well as chronic fatigue, and other hard to diagnose chronic ailments. We also now understand that there is often a mental health component of many claims that also have physical manifestations. This implies a couple of things: First, the distinction between subjective and objective claims that may have been part of the original rationale for the limit is no longer as clearly defined. In addition the distinction between physical and mental health claims is also no longer as clearly defined.

The primary rationale that I hear now for maintaining the limit does not have to do with clear differences in the risk, but rather with concerns for increasing the overall cost (and hence premiums) of the LTD coverage. The concern is that if the limit is removed the product will be sufficiently more expensive that some employers will elect to drop coverage. Hence removing the limit may result in

lower overall access to benefits. I believe this makes an assessment of the cost differential or premium impact an important consideration.

Some Statistics on Mental Health Claims

The following statistics are based on the most recent SOA LTD Claim Termination Study, which is cited in the references below. This study covered claims experience from 2009 to 2017 and involved over 1.8M distinct claims. The study database includes information at the claim level including the primary diagnosis (ICD9 or ICD10) codes, and it is these that are used to identify mental health claims. Note that many claims have multiple conditions, some physical and some mental, and whether or not the limit applies is a judgement call made individually by the claims examiner. All claims in the study have a policy plan indicator specifying the mental health limit, regardless of the diagnosis, but we use the diagnosis codes as a proxy to capture whether or not the limit applies to each particular claim.

Here are some observations:

More than 99% of all claims have a mental health contractual limit. The vast majority have a 24 month limit.

Between 7% and 8% of all claims are designated as primarily mental health claims and are subject to the limit. This numbers was above 8% at the start of the study and has declined to closer to 7% by the end of the study. When weighted by monthly benefit these numbers are about a percentage point higher.

Less than half of these claims (44%) stay on claim until the limit is reached. This means between 3% and 3.5% of all claims are subject to the limit.

Once a mental health claim reaches the limit, about two thirds or 67% go off at claim at that point. This means the limit applies to roughly 2 to 3% of all LTD claims.

It is likely that many of the one-third of claimants that continue to receive benefits also have a physical component to their disability, and so the limit does not apply.

The top mental health disabilities are depression, which makes up almost half (48%) of all mental health claims, followed by bipolar (13%), Anxiety Disorder (11%), and Post-Traumatic Stress Disorder (9%). Other mental health conditions comprise less than 20% of the total. This is some variation in how likely these claimants are to go off claim at the limit. Anxiety and PTSD have a high chance of closing (75%) whereas things like post-concussion syndrome are much less likely to close (25%) suggesting that even though we classify these as mental health claims it is recognized that there are physical components.

The additional premiums associated with the removing the limit

In many states, LTD carriers are required to file their LTD rate calculations and at Smith Group we collect those filings so that we can estimate the value carriers are assigning to different plan provisions. Looking at the filed premium manuals of 17 different LTD carriers we see that the cost of going from the most common 24-month limit to an unlimited plan averages 17.6% with all carriers falling between 9% and 25%.

However, I note that due to the rarity of the unlimited plans, this is a difficult assessment to make and so I believe there is significant uncertainty in the true cost. I also assume that these premium estimates include an anti-selection load, which means that when offering the unlimited provision as an option the

insurance companies will assume that at least some of the employers request this change because they know or suspect that some key employees may be likely to need the coverage. Hence the load for an optional plan design will be higher than what it would be if all policies offered this unlimited provision. Furthermore this potential for anti-selection means that carriers cannot, in principle, use their own or industry experience to assess the true impact on premiums if the limits were to be removed for all claims.

Using the most recent SOA claim termination study I have made an assessment of the cost differential based strictly on claims experience. This specific calculation is to identify those claims that are subject to the limit, and then estimate the additional benefit cost that would be associated with these claims were the limit to not apply. I restricted my study to claims experience from 2014 to 2017.

Some of the statistics stated above are used for this calculation.

Claims with a diagnosis code for mental health disabilities represent between 7% and 8% of all claims with a 24 month M&N contractual limit. Of these 44% remain on claim until this limit is reached. Of these claims that reach the limit, about two thirds or 67% actually go off claim at the limit. The additional assumption I make is that if the limit were not to have applied to these claims, then their remaining claims experience would be like all other physical claims. The reserve table suggest a reserve factor of about 60 at the contractual limit. These numbers imply removing the limit will increase the cost for claims identified as mental health claims by about 90%. Due to the limit M&N claims now represent less than 5% of total claim cost and so increasing this by 90% would add about 4.5% to the overall cost (or premiums) for the coverage.

Given uncertainties in this calculation my opinion, based on claims experience alone, without considering additional claim incidence, is that removing the contractual limit would increase total premiums by between 4% and 8%.

However, this does not include any estimate for increased claim incidence caused by removing the limit, and this is the largest uncertainty in estimating the premiums needed. It is certainly possible that some individuals, being aware of the contractual limit, will decide not to bother filing a claim, but were the limit removed, they would conclude that going through the disability process would now be worth it.

Canadian Experience

Canadian LTD experience is often cited as evidence of a much higher cost estimate for the unlimited provision. Canadian policies do not have a similar limit and in that country mental health claims represent a much larger proportion of the total number of claims. The most recent Canadian claim study covers the period from 2009 to 2015 and this study shows that claims with mental disorders represent 30% of all claims by count. This compares to less than 8% for the most recent SOA study. The most extreme position to take is that this large difference in the proportion of mental health claims is due entirely to the limited plan provision. If this is indeed the case, we would expect almost a five-fold difference in mental health claims, putting the overall cost impact at close to 40%.

Of course, there are societal differences between the United States and Canada which make this comparison problematic. For example, if there is a greater social acceptance of mental health conditions in Canada then this may explain part of the difference. Also, it is certainly possible that the limit itself is contributing to the relative low prevalence of mental health conditions in the US. As I have noted, many

times the line between physical and mental disorders is blurred. In the US, because of the limit, claimants may be focusing on the physical aspects when filing or documenting their claim. In Canada, without the limit, the claimant may emphasize the mental health aspects. This is to the say, that a claim that in Canada would be identified as due to a mental health issue would, in the US be classified as physical. Thus the high percentage in Canada may not represent additional claims at all but a different characterization of the claims.

The Canadian Study does not specify how claimants with mental disorders are determined and so there may also be additional classification differences between this study and the US study. Additionally, in Canada the proportion of mental health claims has been climbing. There is a Canadian study published in 1988 that shows that the proportion of claims from 1984 to 1988 that have mental disorders is about 14%. This study also comments on the fact that the 24 month contractual limit was recently eliminated due to regulatory changes. It is certainly possible that part of the reason that mental health claims increased in proportion is due to the removal of the limit.

Finally, actuaries have commented to me that, unlike in the US where LTD incidence has been declining the overall incidence in Canada has been increasing over the last decade, with an increase mental health claims being an important driver of this change. These comments are based on proprietary information and so I do not have a source for this observation.

The much greater impact of mental health claims in Canada and the US is often cited by US group insurance actuaries as evidence that the additional premiums needed to remove the limit may be greater than manual premium estimates and certainly greater than the existing claims-based estimate. Unfortunately, I don’t know of a way to separate out the additional claims due to the unlimited provision from societal differences and claim reclassifications and so, to my mind, the cost to the US LTD program of removing the limit is highly uncertain, but very likely falling onto the range from 4% to 40%. Just as a reminder, the public rate filings place the value between 9% and 25% with an average of 17.6% I personally believe the high end estimate of 40% is quite unlikely. I am convinced however, that the high level of uncertainty of the true cost is a key reason why many carriers are opposed to removing the limit.

Additional Thoughts

Even if carriers our supportive of removing the limit overall, they are reluctant to do so proactively since if they are the only carrier without the limit they be selected against by employers who feel like they need this additional protection.

Many carriers are concerned about the recent rise in mental health claims. At Smith Group we conduct LTD and STD surveys on recent claims experience pre and post-pandemic, and both products show significant recent increases in mental health claims. This makes carriers even more reluctant to consider removing the limit at this point in time.

However, when considering the cost impacts it is also important to understand that recent disability trends have been very good. Based on claim surveys, we guess that overall LTD claim costs have declined by well more than 10% and probably by as much as 15% since 2010. Therefore considering the cost of the overall program any impact to removing the limit should be considered in the context of that overall improvement in morbidity.

Sources

Any comments on the original reasons for the Mental Health limits are strictly based on conversations, and review of private insurance company documentation.

Public Rate Filings: The estimates of the manual rate costs for removing the limit are based on calculated rate summaries taken from public rate filings. These filings are gathered from several states including OH and NC. For this provision the rate filings are not entirely up to date, but we also do not believe there has been any recent changes to this value. The following table shows the calculated values of different limits relative to 24 months.

Mental & Nervous Limit

Limit Duration	Avg	Min	Max
12 Months	**.980**	.970	.991
24 Months	**1.000**	1.000	1.000
36 Months	**1.050**	1.050	1.050
60 Months	**1.084**	1.080	1.088
Unlimited	**1.176**	1.090	1.250

GLTD2019: The most recent SOA term study can be found here:

https://www.soa.org/resources/experience-studies/2019/group-ltd-experience-study/

The percentage of claims that are mental health claims are listed below:

Pct of Mental and Nervous Claims

	Weighting	
Year	Count	Gross Ben
2009	8.1%	9.0%
2010	8.6%	9.7%
2011	8.5%	9.5%
2012	8.3%	9.3%
2013	7.7%	8.6%
2014	7.5%	8.5%
2015	7.1%	8.0%
2016	7.0%	8.0%
2017	7.2%	8.2%

Source: SOA 2019 LTD Study

Claims are identified by the supplied original diagnosis code (ICD 9 or ICD 10).

The following table shows more detailed diagnoses for Mental Health claims

	Percent of Claims	Percent Making it to 24 Months	Percent Limit Closures
All Claims	100%	44%	67%
Depression	48.3%	43%	69%
Bipolar	13.2%	51%	65%
Anxiety Disorder	10.7%	37%	74%
Posttraumatic stress disorder	9.2%	49%	78%
Other Mental Disorder	3.8%	64%	27%
Post-concussion syndrome	2.7%	48%	22%
Reaction to Stress	2.1%	36%	68%
Phobias	1.6%	43%	80%
Psychosis	1.2%	49%	66%
Alcohol Related M&N	1.0%	26%	63%
Schizophrenia	0.9%	71%	40%
Other Dementia	0.8%	76%	8%
Eating Disorder	0.7%	34%	75%
Other Mood Disorder	0.7%	57%	45%
Obsessive-compulsive disorders	0.6%	47%	83%

The analysis I cite was performed by me and is based on the consolidated database of claims experience that can be found at the above link. The details for the calculation can be summarized below:

Statistics from 2019 GLTD Term Study

Experience Period: 2014-2017

Claims with 24 month limit	**Claim Count**	**Gross Benefit**	
Percent of Paid Claims	7.20%	8.20%	A
Percent that Survive to the limit	44%	46%	B
Percent Closed at the limit	67%	64%	C
M&N w/Limit: Cost per Gross Benefit		20	D
Non M&N: Cost per Gross Benefit		36	E
M&N Reserve Factor at Limit		60	F

Calculations	**Formula**	**Amount**	
Assume $1M of M&N Claims w Limit		$1.0M	G
Total M&N Claim Cost	(G*D)	$20.0M	H
Total Claim Cost Non M&N Claims	G/A*(1-A)*E	$403.0M	I
Extra Cost of No M&N Limit	G*B*C*F	$17.7M	J
Percentage Increase in M&N Cost	I/H	88%	
Percentage Increase in Total Cost	J/(H+I)	4.2%	

Canadian Experience

The more recent study cited can be found here:

https://www.cia-ica.ca/docs/default-source/research/2019/219012e.pdf

The percent of claims represented by Mental Disorders can be found in Table 355 on page 45.

Table 355 Distribution of Claims by Cause of Disability

Cause of Disability	Québec	Rest of Canada	Total
Mental Disorders	41%	25%	30%
Musculo-skeletal	18%	22%	21%
Neoplasms (mostly cancers)	11%	14%	13%
Circulatory	5%	8%	7%
Nervous System	4%	8%	7%
Accidents	9%	10%	9%
All Other Identified Causes	11%	12%	12%
Not Stated or Unknown	1%	1%	1%
Total	100%	100%	100%

The older study can be found here:

https://www.cia-ica.ca/docs/default-source/1998/9824e.pdf

This study includes the following statement on page 8

"From a benefits perspective, the two-year maximum benefit period limitation for mental and nervous conditions was removed to comply with employment equity regulations - at a time when such claims were on an increase."

The following table shows percentages of claims by diagnosis categories:

Table 9

Code Cause of Disability Coded for Cause		Number of Claims	Proportion of Claims
50	Infectious & parasitic diseases	1,515	1.0%
51	Neoplasms	11,866	7.9%
52	Endocrine, metabolic and immunity disorders	2,121	1.4%
53	Blood & blood-forming organ diseases	871	.6%
54	Mental disorders	21,199	14.1%
55	Nervous system and sensory organ diseases	12,630	8.4%
56	Circulatory system diseases	22,203	14.8%
57	Respiratory system diseases	5,079	3.4%
58	Digestive system diseases	4,035	2.7%
59	Genitourinary system diseases	3,120	2.1%
60	Complications of pregnancy and childbirth	1,564	1.0%
61	Skin & subcutaneous tissue diseases	1,278	.8%
62	Musculoskeletal system and connective tissue	35,820	23.8%
63	Congenital anomalies	441	.3%
64	Perinatal period conditions	14	.0%
65	Symptoms, signs & ill-defined conditions	3,527	2.3%
66	External causes of injury & poisoning	16,144	10.7%
69	Homicide, suicide	3,872	2.6%
70	AIDS, HIV	392	.3%
71	Chronic fatigue syndrome	556	.4%
72	Fibromyalgia	86	.1%
73	Diabetes	407	.3%
74	Motor vehicle accidents	495	.3%
75	Other accidents	712	.5%
79	Drugs & alcohol	289	.2%
99	Not converted	17	.0%
TOTAL		150,253	100.0%