

DISABILITY

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ACTUARIAL INSIGHT

Credit Disability Reserves and Recession

by Steve Ostlund

Disability reserves increase during a recession. However, credit disability reserves tend not to increase as much as disability income replacement policies. This is due to various characteristics of credit disability that moderate some adverse effects of a recession. This article identifies these characteristics and suggests a response.

Characteristics of Credit Disability

It is commonly known that disability loss ratios tend to increase during a recession. There are two elements that lead to increased claim payments: first, more claims are filed (increased frequency); secondly, claimants tend to stay disabled longer (decreased termination rates).

Credit disability insurance, like other disability insurance lines, also demonstrates increased loss ratios during a recession. However, the adverse



effects are more moderate than that experienced by other forms of income replacement insurance. The income benefit is generally a much smaller proportion of the total income of the claimant, covering only a loan payment that should be no more than 10 percent to 20 percent of total income. Thus, over-insurance is less likely than with income replacement policies.

In credit disability insurance the increased claims are generally due to a greater number of claims, not increased severity. The severity impact is limited because the maximum benefit period is determined by the remaining term of the loan. At the onset of disability some loan payments have typically already been made, effectively reducing the insurance benefit period. This is different from income replacement policies where the benefit period is a constant period of time measured from the onset of disability.

Since the increased claim volume in a recession is more likely due to increased frequency the actuary should examine the reserve factors applied to each claim very closely. If the actuary has performed claim studies in the past, one opportunity for a more precise determination can be based upon cause of claim data.

Cause of Claim Analysis

In a recession, the preponderance of additional claims tends to be those with less precise diagnosis, i.e., back or mental causes. There are also more surgically related claims, or elective claims, with short recovery periods. If claim studies have been performed in the past look at the ratio of those causes with generally shorter length of claim to those with generally longer length of claim. If the proportion has

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CLAIMS INSIGHT

Benefits of establishing a Dedicated Psych Unit

By Mark Raderstorff, MA, CRC, LP

How often does this Attending Physician Statement for a STD/LTD claim come across your desk?

Diagnosis:	Depression
Objective Symptoms:	Tearfulness, lethargy, low self-esteem
Treatment:	Prozac 20 mg
Frequency of Treatment:	Every one to two months
Prognosis:	Poor to fair; no return to work for at least six months due to job stress
Signature:	Will Robinson, MD, Family Practitioner



This type of mental/nervous claim with a vague diagnosis, significant work-related stressors, and inadequate treatment is becoming much more common. With rising costs and increasing incidence to employers and insurance carriers, mental illness claims have become a focal point for Disability Management. Industry data suggests that psychiatric disorders are the primary diagnosis for eight to 23 percent of all Disability claims. In my experience, as many as two-thirds of all physical claims have a significant psychological contributor. If a carrier is to make a strong commitment toward Disability Management, specialized resources need to be in place to help manage the psychiatric component of claims. For these reasons, insurers are looking to mental health professionals with the acumen to decipher the existence of psychiatric illness, assess the impact on the claimant's functioning, and identify the appropriate treatment necessary for positive return to work outcomes. Working within the definition of disability for a particular policy, especially as it relates to work-related stressors, can complicate an already complex Disability Management strategy. Many carriers are moving to the establishment of a dedicated psychiatric unit to meet these challenges and impact the bottom line.

What Is a Dedicated Psych Unit?

A dedicated psych unit is a specialized group of claim specialists and behavioral health professionals who adjudicate and manage mental/nervous claims or those

physical claims with strong psychological components. The team members consist of trained mental health professionals with extensive clinical experience; psychiatric nurses, social workers, psychologists and psychiatrists. The claim specialists and vocational experts within the team typically have an interest or training in mental health. The size of the team is dependent on the volume of mental/nervous claims.

Advantages of a Dedicated Psych Unit

The subjectivity inherent in a depression or stress claim creates opportunity for inconsistency in claim adjudication and case management. Assessment of total disability relative to mental illness can produce interpretations that lead to variation and in some cases divergent outcomes within a claim department. Adding further complexity is the broad range of mental health care provided by attending physicians relative to treatment and work or functional capability. There is no CT or MRI to objectify an individual's depression and precisely target a specific treatment and duration of disability. A dedicated psych unit brings additional expertise to your claims management staff that judiciously determines the degree of the mental illness and its vocational impact. Results do affect an organization's bottom line on many fronts. Most immediate is the improvement in adjudication decisions. Longer term results should include reduced claim duration and more return to work out-

comes. Positive claim outcomes will have an obvious impact on reserve reduction. I know of one Disability insurer that saw a 43 percent increase in monthly closures of mental/nervous claims after the first year of a psychiatric unit's operation. An estimated \$2.4 million in reserve savings was realized.

How Does a Dedicated Psych Unit Work?

The psychiatric case manager (PCM) brings mental health expertise to the claim staff within the team. The PCM offers the opportunity for clinical records review, attending physician consultation, assessment of appropriate care and treatment, assistance with action planning, coordination of return to work initiatives and management of external vendors. Through either telephone interviews or written correspondence, the PCM gathers information from a variety of sources much like the claims professional.

Communication with the disabled employee, employer and attending physicians is available, as is information gathering from more arcane sources such as school transcripts, past employers, legal documents, family members, and other collateral parties. Through evaluation of the claimant's altered level of functioning, the PCM can assess whether the symptoms reach a threshold of severity that render the claimant functionally impaired to the degree that prohibits performance of essential functions of an occupation.

Via this team effort in adjudication, benefit eligibility can be determined.

Action planning can then ensue to identify those Disability Management services that can be most effective in moving the claim to successful resolution. This is where the clinical knowledge and experience of the unit member plays a critical role in timely and successful return to work. Many disabled workers, such as the one reviewed in the APS previously mentioned, seek initial treatment of their mental illness from a trusted family doctor. A PCM can insure the claimant receives appropriate care via analysis of the treatment plan and making a ‘collegial’ phone call to the provider of health care to discuss and hopefully agree on treatment options. These usually consist of a combination of enhanced medication management and intensive psychotherapy. This approach was recently supported when the *New England Journal of Medicine* (May 18, 2000, Volume 342, Number 20) reported that the optimum treatment approach to mental illness is a combination of medication and frequent psychotherapy. Persuading the attending physician to take this course and move the patient toward

more focused treatment to reduce the duration of disability is a primary strategy and outcome of the dedicated psychiatric claim unit.

Another barrier to recovery and RTW that frequently surfaces is one in which the mental health provider assumes he or she has the patient’s best interest in mind and is reluctant to release the claimant back to a work environment where a risk of regression exists. Without intervention by a trained mental health professional, this can lead to a stalemate where the provider of care does not wish to pursue a release to work unless there is a change in the employer’s environment, and the employer is reluctant to offer any flexibility with job accommodations. This is where the skillful PCM can target and initiate interventions with both the provider and employer to break this stalemate and develop a reasonable return-to-work plan that benefits all parties.

A dedicated psychiatric unit can provide superior customer service by helping restore claimant functioning, and

reduce costs for the employer and the insurer. A team of claim and clinical professionals focused on mental illness claims is an effective means to address the behavioral components of all claims. The Department of Health and Human Services has reported that depression is expected to be the second leading cause of disability worldwide in the 21st century. Use of psychiatric impairment teams can have a significant impact on mental/nervous claim management to the benefit of the employee, employer and insurer. ■



Mark Raderstorf, MA, CRC, LP is a licensed psychologist and president of Behavioral Management, Inc., a Minneapolis-based firm that assists employers and insurers in staff training, consulting and case management of psychiatric

disability. He will be speaking on the topic of the Dedicated Psych unit at the ING Re 17th Annual ROSE Seminar, July 22-25 in Minneapolis.

CREDIT DISABILITY RESERVES

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changed, the tabular factors may need adjustment in a recessionary environment to avoid over-stating reserves.

Adjustment Process

The chart shows a simplified situation where the number of claims has increased 10 percent, but only at the short durations. When the experience is fully developed, months on claim, i.e., total claim payments, will have increased only 4 percent not 10 percent. Knowing that shorter duration claim causes have been the source of the additional claims, claim reserve factors could be reduced by the ratio of 104/110. This will result in a lower estimate of incurred claims and avoid a situation where excess reserves are set up, only to be released later. On the other hand, if the increased claims are due to causes that have historically had longer durations, then a larger adjustment factor is required to reflect the possible malingering effects. This factor would be calculated in a similar fashion. (See table.)

Cause	Number of Claims	Average Duration	Pre-Recession		Recession	
			Number of Claims	Average Duration	Number of Claims	Average Duration
Cardio-Respiro-Cancer	16	10	16	10		
Digestive-Genital	16	3	26	3		
Musculo-Skeletal	48	8	48	8		
Mental-Neurological	10	13	10	13		
Accidental	10	5	10	5		
Total	100	7.7	110	7.3		
Total Months of Claim		770		800	104%	
			c.p.	847	110%	

Obviously, it is still necessary to follow all legal requirements. Discretion is allowed if the actuary can justify an experience based deviation from standard. A change in the ratios of various claim causes is an experience factor that should be reflected in reserve adjustments.

Conclusion

While total claim payments will typically increase during a recession it is possible to evaluate cause of claim information to adjust claim reserves. This allows the reserving actuary to avoid overreacting and establishing

excess reserves. It is a challenge to establish adequate reserves without being too conservative. The process of making claim reserve adjustments based upon cause of claim analysis adds a tool that can be used to achieve this goal. ■



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UNDERWRITING INSIGHT

Dual-wage Earners: More than meets the underwriter's eye

by Curtis S. Zepeda and Gerald T. Bannach

Much of what underwriters' use today for rating algorithms and underwriting processes for pricing LTD risk dates back to the late 1960s and early 1970s. During that time, it was common for a single-wage earner to provide income for the family. According to the United States Department of Labor, only 35 percent of married couples were dual-wage earners in 1960. By the year 2000, more than 66 percent of married couples were dual income families. This change in economic demographics has a direct impact on family replacement ratios: something near and dear to the hearts of all LTD underwriters. We have outlined in this article the effects of dual-wage vs. single-wage households on the replacement ratio picture. We also pose some questions on what we think underwriters can do to factor this "new" demographic into their underwriting.

In comparing a single-wage earner's replacement ratio to dual-wage earners' replacement ratio, a number of assumptions were made:

Single-wage Earner Annual Income = \$60,000

Dual-wage Earner Combined Annual Income = \$60,000

Combined Federal and State Tax bracket of 29 percent

We compared 100 percent employer-paid to 100 percent employee-paid plans at the three common monthly benefit percentages of 50, 60 and 67. While we realize most carriers are not writing 67 percent benefit plans on a 100 percent employee-paid basis, we wanted to show a complete comparison of scenarios.

Figure 1

Dual-Wage Earners, each earning \$30,000 per year, one disabled

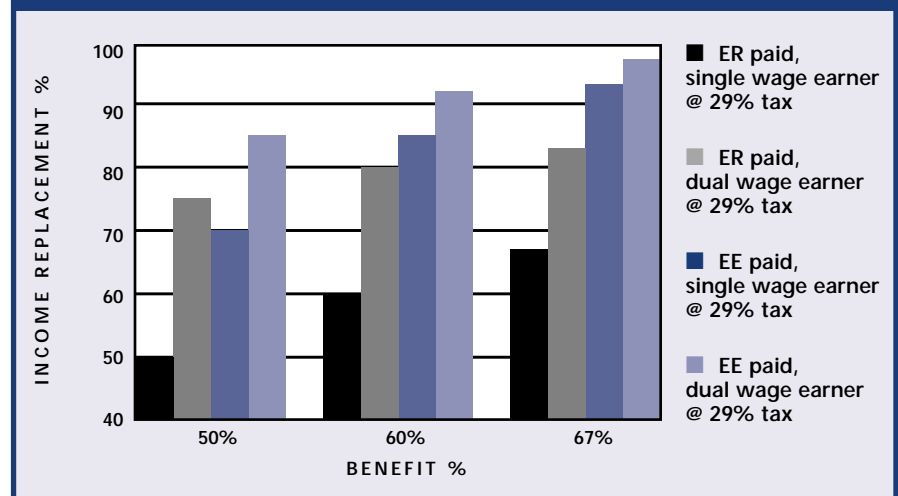


Figure 1. The employee-paid plan yields the highest replacement ratios for both single and dual-wage earners except in the 50 percent plan. At the 60 percent monthly benefit this results in ratios of 85 percent and 92 percent, respectively. The dual-wager earners have 7 percent more income. Even more interesting is what happens to the employer-paid illustration. At 60 percent monthly benefit, the difference between the single-wage earner and dual-wage earners is 20 percent; a 60 percent and 80 percent replacement ratio respectively. Also, looking at a 67 percent monthly benefit, which is not uncommon for an employer-paid plan, we get a 16 percent difference between the single and dual-wage earners at a 67 percent and 83 percent replacement ratio respectively.

DUAL WAGE EARNERS

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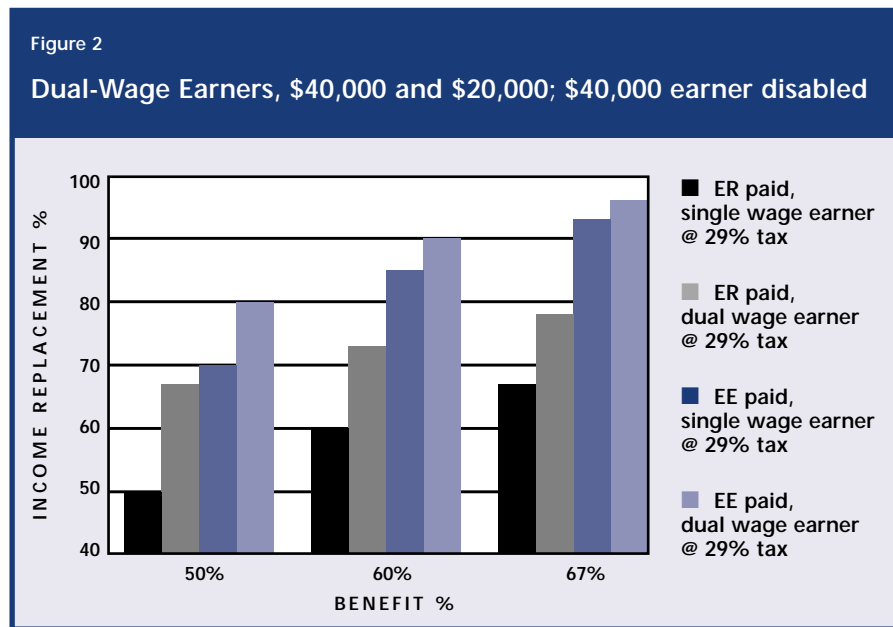


Figure 2. Once again, the dual-wage earner’s replacement ratios are higher than the single-wage earner. In the employee-paid 60 percent plan it drops slightly to 90 percent and for the employer paid plan it now is 73 percent. The difference between the single and dual-wage earner is less in this example but still causes concern.

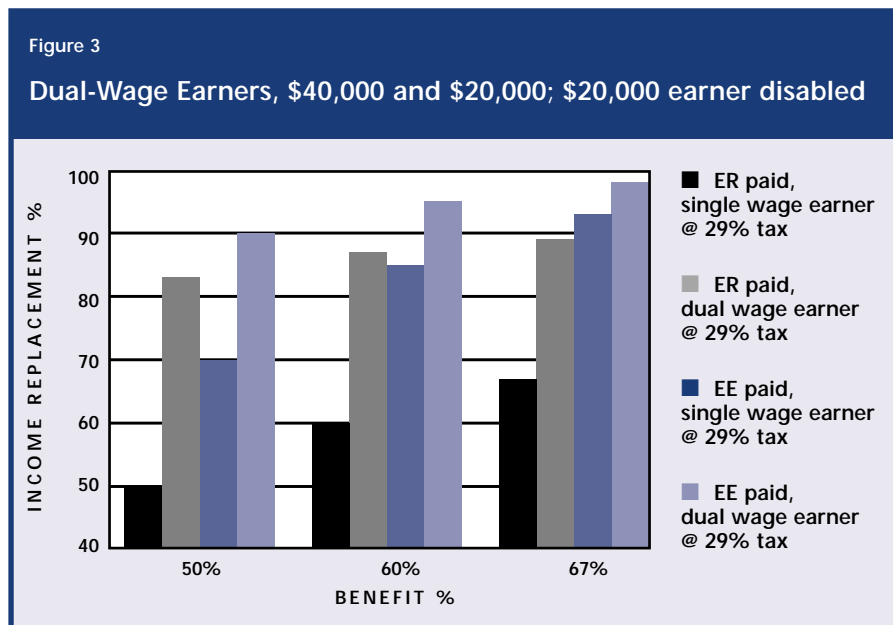


Figure 3. Here we have the most extreme differences between single and dual-wage earners for both the 60 percent monthly benefit employee-paid plan and the 67 percent monthly benefit employer paid plan. An interesting change shows up in the employer paid plan. Here the difference between the single-wage earner and dual-wage earners grows to 22 percent with the dual-wage earner’s replacement ratio reaching 89 percent. While the employee-paid plan yields only a 10 percent difference, it is alarming that the dual-wage earner’s replacement ratio is pushed to 95 percent.

Most underwriters would be comfortable in offering a 60 percent employee-paid plan or a 67 percent employer paid plan. Looking at these two common plan designs, we observed that the replacement ratios for dual-wage earners is higher for all employee-paid plans in every illustration. While we recognize that underwriters use more caution when underwriting employee-paid plans, the replacement ratios for both the single-wage earner and dual-wage earners are still disturbing. An underwriter likely views an 85 percent replacement ratio as undesirable. However, a replacement ratio approaching 95 percent is unacceptable.

More surprising was the impact the dual-wage earner had on the employer paid plans. In all our examples, the difference between single and dual-wage earners replacement ratios were always more pronounced. And in the example where the lower paid wage earner was disabled, the spread was the largest and the replacement ratios approach 90 percent.

In addition to the replacement ratio, there are other considerations that add to or take away from a family’s income. These include:

SINGLE-WAGE EARNER	DUAL-WAGE EARNERS
Increase in medical costs	No increase in medical costs assuming the working spouse has medical available at their employer.
No work related expenses	Less work-related expenses
No change in childcare costs	Possibly less childcare costs

What can an underwriter do to account for the impact of dual-wage earners’ higher replacement ratios? Should marital status be assumed for covered employees over age 30? Should marital status be requested on the census and considered in our underwriting? Do we restrict plan designs when there are a high number of married couples in a group? What should these restrictions be? Should we continue to strictly limit the own occupation for lower paid or

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DUAL WAGE EARNERS

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part time workers to two years or less? Should unlimited M&N be an executive only benefit? Is there a way to manage these claims better?

These are just a few questions we came up with. Do you have any others? If you have any thoughts that you would like to share, we would like to hear from you. Please contact Curt Zepeda at curtis.zepeda@reliastar.com with your thoughts on this subject. We plan on publishing your comments in an edition of *Disability Notes* later this year. ■



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Gerald T. Bannach, CLU, FLMI, ARA has more than 14 years experience in the disability industry and is Managing Director, Disability Reinsurance at ING Re.

Upcoming Disability Insurance Meetings

Following is a partial list of industry meetings dealing with a variety of disability insurance topics. If you know of any other disability insurance conferences that could be added to our list, please let us know.

CONTACT	LOCATION	DATE
CLHIA — ANNUAL CLAIMS SECTION MEETING		
Contact: Irene Klatt (416) 777-2221	Halifax, NS	May 8-11, 2001
INSURANCE REHABILITATION STUDY GROUP		
Contact: Dan Abramowski (612) 342-7212	Portland, ME	May 20-23, 2001
SOCIETY OF ACTUARIES — HEALTH & PENSION		
Contact: Liz Hirz (847) 706-3500	Dallas, TX	May 30-June 1, 2001
CASE MANAGEMENT SOCIETY OF AMERICA (CMSA)		
Contact: Dan Abramowski (612) 342-7212	Nashville, TN	June 5-9, 2001
DORT (HIAA) DISABILITY OFFICERS ROUND TABLE		
Contact: Diane Fulton; www.hiaa.org (703) 968-8863	San Diego, CA	June 13-15, 2001
CANADIAN INSTITUTE OF ACTUARIES — ANNUAL CONF.		
Contact: Joanne St. Pierre, www.actuaries.ca (613) 236-8196 x106	Toronto, ON	June 18-19, 2001
GUAA — ANNUAL MEETING		
Contact: Bill Wade (402) 467-7339	Montreal, PQ	June 24-27, 2001
ING Re ROSE® SEMINAR		
Contact: Mark Taylor (800) 378-6965	Minneapolis, MN	July 22-25, 2001

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