**RECORD OF SOCIETY OF ACTUARIES
1977 VOL. 3 NO. 4**

INDIVIDUAL DISABILITY INCOME PROBLEMS

Moderator: MARTIN L. ZEFFERT. Panelists: ANTHONY J. HOUGHTON, BENJAMIN J. JONES, WILLIAM J. TAYLOR*

1. What are today's serious issues and trends in disability income insurance and what should the insurance industry do about them?

2. How serious is the problem of overinsurance?

3. How have pricing and financial reporting been affected by current experience?

MR. MARTIN L. ZEFFERT: Mr. Benjamin Jones, President of the Monarch Life, has just come back from a Health Insurance Association of America (HIAA) meeting in Montreal and he is going to report on the activities of the HIAA.

MR. BENJAMIN F. JONES: It was not possible for me to prepare my remarks for this meeting until this past Sunday afternoon because I did not know what action the Board of Directors of the HIAA would take with respect to a recommendation made to it by a special blue ribbon committee to study the disability income business. That vote, I am pleased to report, was unanimous and the recommendations were accepted substantially as they were made. It is most appropriate that the Society of Actuaries be the very first to learn of the action that has been taken for it has given the disability income business an opportunity to come together and perhaps begin to solve the problems we are encountering. And solve them we must or, for the second time in this century, some companies could be unwilling to offer disability income coverage because of the continuous losses that they have already sustained and the unfavorable trends they foresee in the years to come. A study of our current results as well as those of the early 1930s seems to indicate that the primary problem is claim durations.

The stock market crash and the deflation which followed caused the disability income contract to become a most valuable piece of property and for many people their only source of income. There were no mandated or social insurance programs available. Many of those people were tragically disabled, but some found ways to qualify for benefits because it was profitable to do so. There was no raging epidemic in our nation at that time, just an extreme scarcity of jobs.

The claim durations we are experiencing today are also not supported by any known change in our nation's health which is striking down our workforce. Quite the contrary. We have seen major advances in medical treatment, rehabilitation & prosthetic devices. While the incidence of disability has remained reasonably stable the durations have grown, because the money is good and so are the fringe benefits.

A job today is the best hedge against inflation. It would seem that there should be every incentive to continue working as long as one could and

*Mr. Jones, not a member of the Society, is President of Monarch Life Ins.

returning to work just as soon as possible after a disability. But that is not what has occurred. Claim termination rates due to death and resumption of employment are at an all-time low. The answer appears to be as clear today as it was in the 1930s. In too many instances, it is more profitable not to work.

In 1967, 1,193,000 workers were receiving disability income payments from Social Security. Today, that number is 2,755,000, a 131% increase. Add to this two million more who receive disability benefits under the government's supplementary security income plan, and then 300,000 federal civil service disabled employees and another 144,000 with service connected disabilities. In addition to these benefits are all the other systems of compensation - workmen's compensation, state disability plans, auto, employee benefits, sick leave, group and association coverage, waiver of premium, credit H&A, excess medical coverage and a wide range of privately purchased long and short term disability income contracts. Put them all together and what have you got? The ultimate individual tax shelter, which may well be the reason why the Social Security Disability Trust Fund is almost broke and most of the rest of the programs providing disability income benefits to the American public are experiencing unfavorable results.

The crisis in the Social Security Disability Trust Fund is causing everyone to search for the reason. It seems to me it was spelled out pretty clearly in the HEW report entitled "Experience of the Disabled Worker Benefits Under OASDI" (Actuarial Study #74) published in January of 1977. That report points out that progressively healthier individuals have been granted benefits and progressively healthier individuals have been allowed to stay on the rolls. Claim termination rates through death and recovery are decreasing continuously. Perhaps it is because of the extraordinary difficulty to determine disability qualifications when it starts and when it ends.

A birth certificate is usually all that is necessary to qualify for a retirement plan. A death certificate is generally the proof for survivors' benefit. There is little room for manipulation with respect to claim payment or benefit. Such is not the case where disability insurance is concerned. In many instances it is a self-assessed subjective decision and medical support can usually be obtained.

Just look at what is happening to Social Security. When disability payments first began, it was considered to be a relatively small part of the program. The majority of the money was to serve elderly clients and the dependents of those who died prematurely. As late as 1970, the case-load was estimated to be two thirds retired and dependents with one third disabled. Disability was given a substantial boost in 1974 under the government's supplementary security income program. Now over half of the SSI'S 4.2 million clients are the disabled. Altogether, the disability portion will absorb a hefty 60% of the total Social Security budget. Three out of every four new applicants coming into the system are claiming disability and an unexpected number of them are younger people.

Why? No worries, no responsibility (other than to maintain your medical status as a disabled person) and an ever-increasing amount of tax free income. There is a distinct parallel between the losses that we are experiencing in the disability income business and the sharp upsurge in

nationwide arson. The fire and casualty companies, like their counterparts in the life and health industry, have been preoccupied with meeting competition. Fearful of criticism and concerned about the threat of punitive damage suits, they have found it easier to pay a claim than to contest it. It is extraordinarily difficult to find and convict an arsonist. It is equally difficult to refute, conclusively, persons who say they are disabled. I believe that the primary reason why the private and public disability income programs are having problems is because far too many people find it is profitable to malinger or to deliberately feign symptoms for personal gain.

The Board of Directors of HIAA has recognized the major role that individual, group and franchise disability income contracts have in providing economic security and, on May 17, appointed a special committee to study disability income business. The committee was asked to study the extent of present and potential overinsurance, the effect of its cost to the public and to suggest appropriate solutions. It was agreed that the committee should try to develop data which would be persuasive to legislators, the general public and members of the insurance industry about the overinsurance problem. The committee was also to develop persuasive evidence that the companies themselves could not rectify the problem.

By August 19, we reached general agreement as to the nature and intensity of the problem as well as the steps to be taken. At its inception, the committee leaned toward the view that the best solution rested with the regulators and legislators. As a result of our deliberations, however, we have reached just the opposite conclusion. We did not believe that the evidence was persuasive enough to convince legislators that laws should be promulgated which would relieve the insurance companies from paying benefits at the time of claim, since the majority of our policyholders had purchased the coverage for just such a contingency. In the light of political reality, the legislators cannot bring themselves to take actions which appear to protect the insurance industry at the expense of the average citizen. We have therefore been led to the conclusion that the solution rested with the companies and this could be accomplished most effectively by utilizing the resources of the HIAA.

The motion was made to the Board of Directors that the HIAA use its resources to promote the development of programs to assist member companies, and others who provide disability income benefits, to function more effectively and to raise the level of attention of the HIAA to the disability business to the level afforded the health business.

A second motion was made that the Board of Directors establish a Disability Income Committee whose principal function would be doing research into areas directly affecting the disability income business, educating and informing the industry on problems that have been identified and recommending appropriate solutions. The committee would address itself to both voluntary and mandated governmental programs, and would examine a wide range of subjects including underwriting, claim management, techniques to avoid overinsurance, replacement ratio principles, the exploration of Social Security offset ideas, the examination of the feasibility of establishing a central claim and underwriting index, consideration of alternate contract

language, the development and dissemination of statistical data which relate to overinsurance and consider the exploration of special educational seminars. The companies would act on their own initiative in using HIAA resources because of anti-trust considerations.

It was also suggested to the Board that HIAA use its resources to make an immediate campaign to influence Congress to restructure the Social Security disability insurance program. It is imperative that benefits be decoupled, the benefit formula be revised, and a reasonable and stable replacement ratio be established.

The Board accepted the special committee's recommendations except that the Disability Income Committee would only be given a two year life span in order to judge its effectiveness. So we have made a start, we have a chance and we must take full advantage of it for we may not have another opportunity.

MR. ZEFFERT: Our next speaker is Bill Taylor, Second Vice President and Actuary of the Massachusetts Mutual.

MR. WILLIAM J. TAYLOR: The biggest single problem we have in disability income today is overinsurance. Virtually every industry meeting for the past two years has addressed this problem. A natural reaction is that this subject has been talked to death and we should give it a rest. After all, we do have lots of other problems in disability income besides overinsurance. However, my contention is that if we do not solve the overinsurance problem, it will not do any good to solve the other problems. So, you are going to hear more about overinsurance.

Ben Jones has told us about what the HIAA has accomplished and in what direction they are heading. My objective this morning is to motivate you to think positively about solving this problem, stimulate a discussion of various things we should be doing to solve the problem and precipitate more action from all of us towards solutions.

One final introductory remark. My contention is that most of our problem has been caused by flagrant violation of basic fundamental principles. By the same token, a key aspect of the solution is the affirmation and enforcement of fundamental principles in this area.

First, what do we mean by overinsurance in disability income? A definition I suspect we can all agree is correct, as far as it goes, is simply a benefit large enough to reduce, or eliminate, the insured's motivation to work. I contend that we are never going to solve our overinsurance problem without a consensus on an objective definition of overinsurance. Let me define gross overinsurance as a benefit sufficiently large that a cut in net income results from returning to work. Here we have an objective definition

of a condition not only permitted by law, but actually created by law! It is not sufficient to eliminate just the gross overinsurance - we must eliminate overinsurance in general.

The following example, which I put together almost a year ago, provides a little insight into this problem. Consider a 27 year old salesman covering his home state of Connecticut by car. Assume that he is married, has 2 children, and has been earning exactly the Social Security Wage Base since age 21. Also assume that the only Disability Income coverages are his Social Security, workmen's compensation, and primary No-Fault auto insurance. This individual is potentially underinsured, overinsured, and properly insured - depending upon the cause and probable duration of the disability.

If he should become disabled by a cause unrelated to his employment or auto travel and with a prognosis of recovery within 12 months, he is ineligible for any of the benefits and, unless he has substantial outside resources, he is underinsured.

If we increase the seriousness of his disability, he may become eligible for Social Security and, if and when the Social Security claim is paid, he would be overinsured. Specifically, he would receive a tax-free Social Security benefit of $990 per month. If he used a standard deduction, he would have paid $1,613 in Federal Income Tax, plus $895.05 Social Security contributions on his $15,300 income for 1976. (Connecticut has no state or local income taxes.) If we assume he had annual insurance and annuity premiums subject to Waiver of Premium of $500, and job-related expenses of $500, then his net income, after tax and after expenses which have been eliminated, would be $11,792, or $983 per month. His Social Security disability income of $990 would be slightly more, so there is a negative financial incentive to return to work. However, during the waiting period and the usual delay in approving a Social Security claim, he would be without income and would consider himself underinsured.

If we keep the seriousness of his disability the same and change the cause to work-related, then workmen's compensation of $189 per week or $819 per month is the only benefit payable. This represents a cut of $164 per month or 17%, which may or may not be sufficient financial motivation to return to work.

If we make the disability more serious and arising from an auto accident while traveling on business, all three coverages provide a benefit and he is suddenly overinsured throughout. Until total A&H benefits of all kinds reach $5,000, he would receive $200 a week from his No-Fault auto insurance. This, added to workmen's compensation of $189, produces a total of $389 per week or $1,686 per month. Thus our salesman is better off to the tune of $703 per month on a bottom line basis until the No-Fault auto runs out, at which point he would have workmen's compensation only for a brief period. Social Security may offset workmen's compensation and, in our example, the total of the two coverages would be reduced from $1,809 to $1,020 per month. Although the benefit is reduced substantially, overinsurance is clearly <u>not</u> eliminated since there is a profit of $37 per month.

When we look at the above example as actuaries, we are naturally concerned about the overinsurance that exists. However, when you look at that situation from the point of view of the insured, you've got to be concerned

about the big gaps in the coverage which could result in his being wiped out financially. My contention is that if we hope to be successful in eliminating overinsurance, we must be equally concerned about eliminating that underinsurance.

Let me next try to convey to you why I'm so concerned about this problem. Although we have seen some of the results of overinsurance in the form of higher morbidity, it is the potential results which I find truly frightening.

We can hypothesize that the extra morbidity from overinsurance should be related to two key factors. First, if the insured is not aware of the fact that he is overinsured then the presence of overinsurance will not increase morbidity. Our second factor is the degree of overinsurance. If the insured's motivation to work is only reduced, then the impact would probably be higher morbidity costs which might require a significant increase in premiums - a serious but still manageable problem. When the insured's motivation to work has been eliminated, then we can expect to get some "disability retirements." That is, the insured may feign disability and retire on his disability benefits.

The cost of such disability retirement can vary widely, depending upon the attained age of the insured, the waiting period, the maximum benefit period, and the assumptions used in valuing such cost, but, for a long-term disability benefit, all of this variation is over a range which leads one to the conclusion that you cannot price for disability income overinsurance.

As an example, let us consider a benefit to age 65, with a 30-day wait, with an insured becoming disabled at attained age 35. Using reasonable assumptions, the cost per dollar of monthly income for each legitimate claim is $2.53; whereas the cost for a "disability retirement" is $152.23. Thus, we see that one "disability retirement" is equivalent to 60.17 legitimate claims. Expressed in another way, if 1% of our legitimate disability claims should become "disability retirements", then we should experience a 59% increase in our morbidity cost spread over the life of the claim. This, incidentally, is another insidious aspect of the cost of disability retirement; namely, it doesn't show up in one large cost, but rather in a series of smaller costs over the entire lifetime of the claim.

Fortunately, most people don't have any knowledge of their Social Security disability benefit. I suspect that most of our insureds that are overinsured by Social Security don't realize it until they have a disability serious enough to apply for Social Security benefits. Others probably find out about it during a short-term disability and may be tempted into a "disability retirement".

If all of our insureds were aware of their total benefits, then we should expect an increase in claims frequency. If 1% of our insureds decide to initiate a claim as a "disability retirement" then based upon our age 35 example, we would expect an extra morbidity of 1,267%, again spread over the life of the claim.

All of the above figures are merely meant to represent the kind of a ball park we are in and not any precise measure of the cost of a "disability retirement." They do, however, lead one to hypothesize the following vicious circle. If overinsurance induces even an occasional

"disability retirement", the adverse financial consequences are significant. If the company reaction to the deteriorating morbidity is an increase in premium rates, then the anticipated results would be to induce more insureds to seek a "disability retirement." Also, publicity given to the problem will make more insureds aware of their total disability benefits, and if financially attractive, induce more "disability retirement" claims.

Increasing incidence of disability retirements can readily cause the need to increase the rates by doubling and even greater. As the rates are increased to "unreasonable levels", more and more "reasonable" insureds will feel justified in seeking a "disability retirement." If overinsurance were universal and substantial, the limit to this vicious circle would be a premium sufficient to fund an immediate annuity which, of course, is absurd. All of the above lead us to the conclusion that we cannot price for any significant amount of overinsurance.

Finally, a list of do's and don'ts:

1. Do not try to eliminate overinsurance without also trying equally hard to eliminate underinsurance. If we expect any outside help, our approach must be that both overinsurance and underinsurance are against the public interest - not that the insurance industry is losing money.
2. We should put our house in order before we seek outside assistance.
3. We should define overinsurance and then relate our underwriting rules to it. Specifically, participation limits should be in terms of after income-related taxes, rather than gross earned income, and estimated, rather than average, Social Security benefits should be deducted for each applicant.
4. A coordination of benefits provision will not work with our present product. We cannot expect to collect premiums year after year and then reduce benefits at the time of claim. There must be periodic re-underwriting to validate the amount of benefit combined with return of premiums on those policies which have a forced reduction in benefit.
5. We should do everything possible to get the Social Security Act changed to provide a cap on Social Security benefits.

MR. ZEFFERT: The next speaker is Tony Houghton of TN&W in St. Louis.

MR. ANTHONY J. HOUGHTON: My presentation will cover several topics including claim reserves, pricing assumptions, GAAP assumptions, and validation of problems by actuarial studies.

The under-reserving of disability income claims can disguise the actual experience for several years and delay a company recognizing a financial problem until its solution is more difficult. For about 10 years the use of the 1964 CDT has been a minimum requirement for claims of over 2 years and has generally been found satisfactory for claims of three durations. During the first two years of disability, companies have been allowed to use company developed factors or procedures which experience has proven

places a sound value on the liabilities. In my role as a consultant, the greatest problems that I have encountered are with these early duration claims where an arbitrary factor such as 3 or 5 times the monthly indemnity has been used without a good follow-up method to test the validity of the factor used. In one instance the follow-up method determined the amounts paid on such early duration claims during the next 12 months and divided by the number of open and pending claims to test their factor. This method left out the continuing liability of those claims still open after 12 months and, therefore, is a theoretically faulty method.

Without going into further detail, let me state that the proper testing of reserve factors is extremely important.

Another area where we see problems with regard to claim reserves is under special definitions of a compensable disability claim. For example, under a "his occupation" definition of disability clause, an insured might have been disabled for 2 years and can potentially receive benefits for 3 more years if he cannot return to his own occupation or for 10 more years (to age 65) if unable to engage in any occupation consistent with his training, education, and experience. Assume in a hypothetical situation that an insured is in reasonably good health but unable to continue his own occupation and is currently actively employed in another occupation. Should the claim reserve be based on a 10 year maximum future duration or should it be based on a 3 year maximum future duration? In the case of the latter period of 3 years, there may be no termination of disability probability because the individual is already actively at work. The benefits for the next 3 years are based on survival. What is the proper handling of a similar claim where the insured appears to be in good health but has not chosen to work in another occupation? Would the company be justified in assuming that since it would not consider the person disabled except for the "his occupation" definition, it is justified in reserving only to the end of such period? In some cases a company has a provision that certain losses such as eye sight, limbs, speech, or hearing will be compensated as total disability for the full maximum period without regard to disability status. In these cases, a life annuity for the monthly indemnity covering the benefit period is more appropriate than the 1964 CDT value.

Another example of a non-standard disability provision would be a "house-confinement" definition of disability. The handling of these claims should also reflect the special conditions of the coverage. For example, the policy might be non-confining for 1 year and house-confining thereafter. The status of the insured during the first year in terms of being house-confined might play a part in deciding how to reserve the claim. Similarly for those disabled and house-confined, a larger than normal claim reserve might be required. In the pricing of disability policies, it would seem reasonable that the actuary would take the most reliable data consistent with the risk being offered and build on this. If the underlying data is based on more restrictive underwriting, claim administration, court interpretation and contractual provision, this would be adjusted for as accurately as possible. Therefore, when I hear people express alarm about long "his occupation" definitions because of financial considerations, I wonder if the experience in question because of the "his occupation" definition is worse than anticipated in the pricing. After all, everyone knew it would cost something. The financial question is whether the cost is in excess of the provision in the premium. Of course, other arguments

about social desirability of a long "his occupation" definition are legitimate.

In the same vein, if the actuary feels that a multitude of conditions such as overinsurance, public attitudes about work and entitlement, court decisions and future economic conditions will cause a deterioration in the experience which underlies his statistical data base, the actuary should adjust his claim costs to reflect his best guess of the future. Then the question about the adequacy of the premiums will not be "Is the experience worse than in the immediate past?" but "Is the experience worse than the actuary projected it to be in setting the premium rates?".

One thing that worries me is that the worsening of experience over the last 10 years will be attributed to a single cause such as overinsurance with management instructing the actuary to ignore some or all of the excess claims because the identified problem is going to be handled by underwriting or a combination of underwriting rules and contract provisions. This would not prove completely satisfactory in my opinion, although some of the underwriting changes and contract design changes would be very helpful. I believe some of the problems involve changes in the attitude of society about work and taking maximum advantage of available programs.

If one were to study a large block of business and find that after 90 days of disability there were 10 claims from 1,000 people exposed for 1 year, this might very well be about the number expected. A further study of the 10 claimants might indicate that some were overinsured. Let us say 5 were overinsured and 5 were not. To draw any conclusions about the effect of overinsurance on frequency of claims, one would have to study the status of the other 990 insureds to see if the proportion of overinsureds is substantially different than the proportion in the claim status. I would speculate that the proportion would not be substantially different.

A continuing study of the duration of disability of the two groups of claimants might show a longer duration for those overinsureds. That is what conventional wisdom suggests and that is what I would expect. Therefore, even if the frequencies are about the same, a large average cost may be attributed to those persons overinsured if the claim durations prove what one would logically expect. However, before becoming too worked up about disasterous consequences, it might be well to know how much overinsurance existed in the prior experience of the 1960's. In other words, some of this cost is already built into the statistics which have been used for pricing. The questions that arise are:

1. Is the situation now worse than prior?
2. Is the situation continuing to get even more unfavorable?
3. Can sensible rules reverse the trend, if there is such a trend?

This presentation has raised some questions about the validity of pricing assumptions and suggested that some studies are necessary to give more definitive answers to causes of longer persisting claims. Further examples regarding true cost of "his occupation" definitions and other items could be mentioned, but I believe the point has been made that we are poorly equipped to answer the questions with solid actuarial studies.

Let me now step out of the role of an actuary pricing products to one who might be responsible for certifying to a CPA firm about the appropriateness of the GAAP factors for disability income policies. In one case, I might have been involved in the original construction of the rates and might know exactly what assumptions were used. The accountants now ask me "Are these assumptions now valid, and if not, is it necessary to change them at least for new issues?". If the assumptions are not appropriate now, it would be apropos to construct a gross premium valuation using current assumptions to provide adequacy. It would also appear necessary if there are new assumptions to construct new GAAP figures for newly issued policies even if the prior premium scale did not involve loss recognition after using the current assumptions.

In another case, some other actuary has constructed the rates, and in reviewing the assumptions, I find that the more sophisticated pricing assumptions are not built into the GAAP factors or the latest assumptions for a new premium scale are substantially different than for a prior premium scale. Under these circumstances, and considering the concern about disability income policies, there will inevitably be more pressure by the CPA first to have actuaries test the gross premium adequacy to determine if loss recognition is required. In several cases, we have noted where companies have changed their premium scale, such as for blue collar occupations, and raised their rates quite substantially, and at the same time they wanted to continue to use the same GAAP benefit premiums for these classes of business. In most cases, we find that any underlying reasons which are sufficient to cause premium rates to change substantially are also indicative of changes which ought to cause GAAP benefit reserves to change substantially.

MR. ZEFFERT: The floor is now open for questions and discussion.

MR. HAROLD INGRAHAM: My company is in the unique position of entering this line of business next Tuesday. After hearing Mr. Taylor's comments, I feel like we've just boarded the Titanic. It seems to me that one of the key analyses that must be done in this line is to study the implications of deteriorating experience on the company's surplus. To what extent are companies doing models of various scenarios to exactly test what would happen to company surplus and the implications for policyholders?

MR. ZEFFERT: Disability income policyholders are generally more knowledgeable about their product than life policyholders.

MR. TAYLOR: The disability income field is too volatile to really model because of the overinsurance problem.

MR. WALLACE JOYCE: The HIAA or some other group of companies should be able to construct an acceptable relation to earnings clause which would solve the overinsurance problem and then get it accepted by the regulators. Another area where the industry should take some action is punitive damage suits. In California some dubious claims made on our company have been paid initially before the investigation because our lawyers are afraid of such suits. Maybe the HIAA could help companies contest dubious claims or even sue some claimants for fraud. If some successful suits against fraudulent claims can be made to stick, the temptation to initiate such

claims would be discouraged.

MR. ZEFFERT: Our company has also had some recent claims that I personally thought should be contested. Our attorneys, however, often tell us to pay the claim since that would be cheaper than the potential costs of contesting it.