Group Long Term Disability Experience Study – Self Audit Guidelines
December 31, 2007

1 - General Information

This document provides information that will help participating companies to prepare a complete and precise submission for The Group Long Term Disability Experience Study (study). The success of the study relies heavily on the quality of the information and consistency of the information between participants. We expect to achieve this by providing guidelines, tests and tips to help participants identify and correct data issues before submitting their participating form.

For clarity, we included a glossary that should be reviewed to become comfortable with the expressions used in this document. It should be noted that the glossary does not represent a list of required data elements (*see document "Group Long Term Disability Experience Study - Data Requirements)* but covers data elements needed to derive and audit the required data elements.

2 – Termination rate application

The study intends to develop termination rates that could be used to formulate both pricing and valuation assumptions.

A - Pricing View

Under this view, the price can be deemed equal to the product of *paid claim incidence rate* (probability of becoming disabled and being approved for benefits) and claim severity. The study aims at supporting the development of claim severity. Specifically, the study intends to produce rates that can be used to derive the expected number of months of disability for a newly approved claim. Consistent with this goal, claim exposure starts on the first indemnified day of disability (*paid-from-date*) and ends the earlier of the last indemnified day of disability (*paid-through-date*) or study end date. Under the pricing view, all claims having received disability payments contribute to the study.

B – Valuation View

From a valuation perspective, the goal is to produce rates applicable to claims that are open and approved as of a given valuation date – that is, claims subject to a month-end reserve calculation. Consistent with this goal, exposure starts on the first month-end where the claim is open and ends the earlier of the paid-through-date and study end date. Under the valuation view, some short term claims end up not exposing.

Examples:

- A claim is approved during January 2006, is paid benefits covering December 12th through March 15th and is closed before or on January 31st.

- A claim is incurred in July 2005 but is submitted in May 2006. The claim is approved in June and paid benefits covering December 12th through March 15th and is closed before or on June 30th.

The data elements and audits aim at capturing enough information to allow for a proper determination of exposure for both pricing and valuation applications.

3 – Social Security approval rate

The study intends to perform a Social Security Approval rate study since this can be accomplished with minimal additional information. Participants unable to provide the necessary SS related data will simply not be included in the SS approval study.

4 – Claim Inventory

The study intends to solely focus on long term disability claims meeting the following criteria:

- Have been fully insured since the date of disability: ASO, claims acquired via risk buy-outs, partially insured claims (such as "cash-flow-plus arrangements") should be excluded.
- Have been approved: claims have received at least one disability payment
- Were considered open between 1/1/1997 and 12/31/2006
- Have definitions of disability based on "own occupation" or "any occupation" or "own occupation followed by any occupation". Claims that have definitions of disability based on ADL or Social Security should be excluded.

In some claim systems, multiple claim numbers may be used on the same claim for the purpose of handling unusual plan designs (ex: Core buy-up plan where one claim represents the core portion while another one represents the buy-up portion). Participants already having in place a process to aggregate such claims into a single one should use that process in their submission. We do not ask other participants to merge their duplicate claims – the study will treat each claim separately.

5 - Glossary

Valuation date: the study requires a 2007-12-31 valuation date. Specifically, the data need to be based on the information known as of the end of the day on 2007-12-31.

*System-close-date (*only required for closed claim as of the valuation date): The date a claim is closed on the claim system. If not available, use the latest date the claim had a reserve. If not available, use the latest payment date.

Hint: If this date is not stored in your databases, please use the last day a tabular reserve was held on the claim. If also not available, use the last time a disability payment was performed (check cutting date).

Disability payment: payment where the amount or a portion of the amount covers disability benefits. For example, a payment strictly covering survivor benefit is not considered a disability payment.

Hint: On most claim systems, a claim payment is similar to a paycheck. It includes a stub describing each amount forming the final net amount payable. Some amounts are positive, some negative. Each is accompanied by a description and a period for which the amount is applicable. Some examples:

Example 1)

Type	From date	to date	Amount
Gross benefit amount	1/12/2007	2/11/2007	2,500.00
Reduction for State Disability Benefits	1/12/2007	2/5/2007	-750.00
Payment before withholding			1,750.00
Federal tax Withholding:			-500.00
Net amount paid on 2/13/2007			1,250.00

Example 2)

Type	From date	to date	Amount
Survivor benefit	1/12/2007	4/11/2007	6,000.00
Reduction for prior overpayments	10/1/2006	1/10/2007	-1500.00
Payment before withholding			4,500.00
Federal tax Withholding:			0.00
Net amount paid on 1/15/2007			4,500.00

In the 1st example, the payment is considered a "disability payment" because of the presence of a "gross benefit amount" component. The 2nd example is not considered a disability payment. Most claim systems are supported by databases storing historical benefit payments and their individual components.

CHS: Claim handling specialist - the person actually handling the claim and entering information on the claim system.

CHS-Termination-date: the date specifying the last indemnified day of disability as entered by the CHS.

CHS-Commencement-date: the date specifying the first day of disability as entered by the CHS.

Hint: Generally, the CHS-Commencement-date and the CHS-Termination-date are respectively equal to the paid-from-date and the paid-through-date.

Paid-Through-Date: the latest day indemnified by a disability benefit payment made prior to the valuation date.

Hints: assuming the existence of a database describing historical payments, it is easy to identify the latest check paid prior to the valuation date containing a disability payment. The "paid though date" of the disability benefit on that check represents the latest indemnified day.

Paid-From-date: the first day indemnified by a disability benefit.

Hints: assuming the existence of a database describing historical payments, one needs to identify the first check paid containing a disability payment. The "paid from date" of the disability benefit on that check represents the first indemnified day.

First-paid-date: the day the first disability benefit payment is made (check cutting date).

*SS Benefit (*Social Security Benefit): We consider as SS benefit any offset amount related to SS and any offset amount related to PERS or STRS if greater than $200. If a claim has more than one offset meeting that definition, only the earliest offset should be considered.

SS-Notification-Date: date the existence of a SS benefit was notified to the carrier. If this date is not available, the first date the offset was used for reserve calculation should be used. Alternatively, the check cutting date of the first payment with a SS benefit offset can be used.

Hint: In the rare event where the claim handling specialist is being notified of a prospective offset, the effective date of the offset should be deemed the notification date Examples:

a) *On 6/20/2005, the claim handling specialist learns and enters in the claim system that the claimant has been awarded SS offsets with a retrospective application back to January 2006. The 6/30/2005 reserve is calculated with an immediate SS offset. On July 10th, the disability payment includes the first reduction for SS offsets. The SS-Notification-Date should be 6/20/2005; if unavailable it should be 6/30/05; if not available then it should be 7/10/2005.*

b) *On 9/15/2006, the claim handling specialist learns and enters in the claim system that the claimant will be awarded SS offsets on January 7th 2007. The 9/30/06 reserve is calculated with a deferred SS offset. On January 11th, the disability payment includes the first reduction for SS offsets. The SS-Notification-Date should be 1/7/2007; if unavailable it should be 1/11/07.*

Claim-Maximum-Date: date benefits expire as defined by the benefit duration provision (excluding the application of any contractual limitations). This date is only required for claims that are closed as of the valuation date. It is used to audit the cause of termination.

Hint: some claim system may not directly disclose the benefit expiration date. In that case, participants need to apply the general benefit duration provision in order to generate a proper expiration date. Please do not submit the date where a change in definition of disability occurs nor the date where a benefit limitation provision takes effect (ex: M&N limitation).

Limit-Date: date benefits expire by virtue of applying a limitation provision (ex: M&N). This date is required for all M&N claims regardless of their status (open or closed).

Maxout-term: a termination due to the expiration of benefits as defined by the benefit duration provision (excluding the application of any contractual limitations).

Limit-term: a termination due to the application of a contractual limitation (ex: M&N limitation).

Death-term: a termination due to death.

Hint: It is not uncommon to have incorrect termination codes in a claim system. We encourage participants to check their claim inventory against the Social Security Death Masterfile to identify claims that have terminated due to death but that are incorrectly coded as recovery. If such claims are found, the participant needs to carefully proceed with termination information updates as the death may have occurred after the actual termination. Participants should work with their Committee representatives if they need assistance in performing the Social Security Death Masterfile audit.

Recovery-term: a termination due to a return to work, or no longer meeting the disability definition.

Settlement: a termination due to a commutation of prospective benefits (involving legal issues or not).

Diagnosis code: the primary ICD9 code in effect when the claim was initially approved.

Hint: If the database contains the history of diagnosis codes related to a claim then use the code in effect when the claim was first paid or first reserved. If the database only shows the current ICD9 code then use that code.

6 – Data Layout

We have minimal requirements regarding the presentation of data elements. We only require the data to be presented on a single row (record or line) for each claim. For ease of understanding, we also recommend the following:

- Dates should be expressed as “mm-dd-yyyy”

- Missing information should be left as <*blank*>

7 – Data Element Audit

A - Claim Status

Claim status as of the study valuation date. The following should help convert a participant coding standards to our required coding.

- Open:
    - Claim is open on the claim system because of its ongoing eligibility to disability benefits. *Hints:*
        - Claim open for the purpose of paying survivor income benefits should be considered as closed.
        - Claim open for the purpose of recovering overpayments should be considered as closed.
    - In all cases, claim has a First-Paid-Date prior or equal to the valuation date.

- Closed:
    - Claim is closed on the claim system because it is no longer eligible to receive disability benefits. *Hints:*
        - Claim open on the legal system (suits or complaints) should be considered as open.
        - Claim with currently interrupted benefits (awaiting further proof of disability for example) should be considered as open.
        - Claim closed as of the valuation date that has re-opened between the valuation date and the data submission date is still considered closed.
    - In all cases, claim has a First-Paid-Date prior or equal to the valuation date.

B – Social Security Status

The following should help to establish the Social Security status as of the study valuation date. Participants unable to provide SS data should leave these data elements as <*blank*>.

- Approved:
    - if the SS-Notification-Date exists and is prior to the study valuation date;
    - if the SS Benefit offset was effective before the computation of the 12/31/2007 reserve (or the latest reserve if claim closed prior to 12/31/2007)

- Ineligible due to plan: if the insurance plan does not allow for SS offsets
- Not Approved: all other claims

C – Liability Termination Date and Termination Code

If the claim status as of the valuation date is closed then these field needs to be populated. The following should be applied in order to select the appropriate termination date and code *(note: for all tests below, use the CHS-termination-date if the paid-through-date is not available).*

- If a date of death is available then this should be submitted as the termination date and the termination code should be "death".

- If the payment system shows the payment of a survivor benefit (made prior to the valuation date) then select "death" as the termination code and the paid-through-date as the termination date.

- If the claim system termination code shows "death" then select "death" as the termination code and the paid-through-date as the termination date.

- If the paid-through-date is equal or greater than the claim-maximum-date and the paid-through-date does not exceed the system-close-date by 180 days then select the paid-through-date as the termination date and "maxout" as the code.

- If the paid-through-date exceeds the system-close-date by 180 days then select the system-close-date as the termination date and "settlement" as the code.

- If the system termination code is "settlement" then select "settlement" as the termination code and the system-close-date as the termination date.

- If the payment system shows the payment of a settlement benefit (made prior to the valuation date) then the termination code should be settlement and the termination date should be the system-close-date.

- If the system termination code is "maxout" and the paid-through-date is closer to the limit-date than the claim-maximum-date then select "limit" as the termination code and the paid-through-date as the termination date.

- If the system termination code is "maxout" then select "maxout" as the termination code and the paid-through-date as the termination date.

- If the system termination code is "limit" then select "limit" as the termination code and the paid-through-date as the termination date.

- For all other closed claims, select “recovery” as the termination code and the paid-through-date as the termination date.

D – Benefit Commencement Date

Submit the paid-from-date. If not available submit the CHS-Commencement-date. If not available, add the elimination period to the date of disability and submit the result.

E – Settlement Amount

If the termination code is settlement, the settlement amount needs to be provided. The amount should be the sum of all amounts paid after the system-close-date excluding overpayment refunds.

F – Elimination Period

The contractual elimination period before any adjustments due to sick leave, temporary return-to-work or others should be provided.

G – Length of Own Occ Period

The total contractual elimination period before any adjustments due to sick leave, temporary return-to-work or others should be provided.

H – Mental & Nervous Benefit Period Limit (and Other Diagnoses Benefit Period Limit)

Many LTD policies include shorter benefit periods for claimants with disability caused by some specific diagnoses. These benefit period limits may not be solely based on the diagnosis but may also include other conditions (ex: not being hospitalized). Provide the benefit period limit to which a claim is eligible due to the cause of disability alone. The benefit period limit needs to be provided based on eligibility and not on actual outcomes. Example: a M&N claim is eligible to a 24 month limit because of its cause of disability. Benefits are not interrupted at the end of the benefit period limit because other conditions are not met. The benefit period limit that should be provided is 24 months.

8 – Final Claim Submission Audit

In this section, we assume that participants have assembled all required data elements and are now ready to perform some final audit tests.

- Gender Vs. Cause Of Disability: are all maternity claims coded as female?
- Gender Vs. ICD-9 code: are claimants with codes 600 to 608 coded as male and claimants with codes 614 to 6778 coded as female?

- Gender Vs. first name: for participants with small claim inventory, is gender consistent with claimant's first name?
- Is the first-paid-date greater than the date of disability?
- Are the date of birth and date of disability producing a reasonable age at disability?
- For closed claims, is the paid-through-date greater than the paid-from-date?
- Is the paid-from-date greater than the disability date?
- Is the liability termination date greater than the disability date?
- Is the system-close-date greater than disability date?
- For claims other than the ones with a settlement or death termination code, is the paid-through-date prior to the claim-maximum-date?

As stated in a prior section, we do not request the aggregation of duplicate claims. However, if the duplication is due to an effort to restate or reconstruct a claim, it is important to perform the necessary adjustments to avoid the inclusion of "false" recoveries. For example, if a claim is closed under a certain claim ID and open on a separate ID to fix an issue, the first claim ID could generate a false closure. We suggest the following tests for carriers that may have this type of issues:

- Sort the claim inventory by Social Security Number, disability date and paid-through-date.
- For claims with the same SSN and date of disability, verify if the paid-from-dates and paid-through-dates offer a continuous coverage.
- If they do, the 2 claims should be combined to form a single claim (taking the earliest of the benefit-commencement-date and the latest liability-termination-date and code).