475 N. Martingale Road, Suite 600
Schaumburg, IL 60173
P +1-847-706-3500
F +1-847-706-3599
SOA.ORG

TO: Data Contributor
FROM: Group LTD Experience Committee
DATE: 12/3/2018
RE: Self-Audit Guidelines for Group LTD Termination Study

Group LTD 2019 A/E Claim Termination Study – Self Audit Guidelines

1 - General Information

This document provides information that will help participating companies to prepare a complete and precise submission for the Group LTD A/E Claim Termination 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.

Please note that this document contains a section that is labeled MIB Audit Tests that describe the specific tests that will be performed by MIB as part of the data assembly. Since these tests may determine whether your data will be used, we recommend performing these tests prior to submission. We also suggest a few additional audits.

The primary goal of this study is to refresh the prior study, therefore if there are questions on how you should proceed, or if the instructions differ from the logic used for the last study, please use your prior method.

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 LTD Claim Termination A/E Study - Data Requirements**")* but covers data elements needed to derive and audit the required data elements.

2 – 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 1/1/2009 and 12/31/2017
- 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. Although we would prefer that you do so, we are willing to make exceptions. If you submit claims in the same format as you did for the prior study, that will automatically be fine. If you do not know what you did before, or have other reasons for submitting multiple records, please contact your Data Buddy. As a general consideration, having more than two records per claim is more likely to lead to potential issues.

3 - Glossary

Valuation date: the study requires a 09/30/2018 valuation date. Specifically, the data need to be based on the information known as of the end of the day on 09/30/2018.

Disability payment: payment where the amount or a portion of the amount covers disability benefits. For example, a payment strictly covering a survivor benefit, or a claims expense 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	1/12/2014	2/11/2014	2,500.00
Reduction for State Disability Benefits	1/12/2014	2/5/2014	-750.00
Payment before withholding			1,750.00
Federal tax Withholding:			-500.00
Net amount paid on 2/13/2014			1,250.00

Example 2			
Type	From date	to date	Amount
Survivor benefit	1/12/2014	4/11/2014	6,000.00
Reduction for prior overpayments	10/1/2013	1/10/2013	-1500.00
Payment before withholding			4,500.00
Federal tax Withholding:			0.00
Net amount paid on 1/15/2014			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. This is also referred to in the document as the *Liability-Termination-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).

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 or ICD10 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 diagnosis code then use that code.*

4 – 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 coded as indicated in the data requirements or left as <*blank*> if not specified.

5 – Data Element Audit

A - Claim Status

Claim status as of the study valuation date. The following should help convert any 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 – 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.

C – 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 – Elimination Period

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

E – 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.

F – 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.

6 – Final Claim Submission Audit

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

We recommend making an effort to ensure the consistency of all data elements, especially with regards to those that affect the calculation of exposures and the actual and expected claim terminations. Towards that end, we are providing the audit tests that MIB used when assembling the information for the prior study (modified to reflect current study dates). We reiterate that, due to the expedited timing of this study, there will not be back and forth communication with MIB on the data elements and it is unlikely there will be time for any resubmissions of data, so we recommend you use the audits to identify potential issues before your data submission.

7 – MIB Audit Tests

Data Validation is the process of ensuring that a program operates on clean, correct and useful data. It uses validation rules that check for correctness or meaningfulness of data that are input to the system. Logic Validation Rules ensures that the values in two or more data elements are consistent, e.g., If Claim Status is equal to "Closed" then Termination Code must be coded. These audit rules are designed to identify potential audit issues. At this point, no decision has been made about how to handle any audit issues that arise (however, we are hoping there will not be many because we are following the prior process as much as possible).

DATE COMPARISONS

Date of Birth

1. Date of Birth must be less than Date of Disability minus 16 * 365.25.

Date of Disability

2. Date of Disability must be less than or equal to 12/31/2017.
3. Date of Disability must be less than or equal to Benefit Commencement Date.
4. Date of Disability must be less than First Paid Date.
5. Date of Disability must be less than or equal to Liability-Termination-Date - 30 (if closed claim).
6. Date of Disability must be less than Claim Maximum Date.

Benefit Commencement Date

7. Benefit Commencement Date must be less than Liability-Termination-Date (if closed claim).
8. Benefit Commencement Date must be less than Claim Maximum Date.
9. Benefit Commencement Date must be on or before 12/31/2017.

First Paid Date

10. First Paid Date must be less than 10/01/2018.

Liability-Termination-Date

11. Liability-Termination-Date (if closed claim) must be less than or equal to Claim Maximum Date.
12. Liability-Termination-Date must be on or after 1/1/2009.

OPEN CLAIMS

13. If Claim Status is equal to "Open" then Termination Code must be blank.
14. If Claim Status is equal to "Open" then Liability-Termination-Date must be blank.

CLOSED CLAIMS

15. If Claim Status is equal to “Closed” then Termination Code must be coded.
16. If Claim Status is equal to “Closed” then Liability-Termination-Date must be coded and must be greater than First Paid Date.

ALL CLAIMS

17. If Limited Own Occ Claim Indicator is equal to “Yes” then Length of Own Occupation Period must be coded and a positive integer. If no, should be blank.
18. If Mental & Nervous Benefit Limit Indicator is equal to “Yes” then Mental & Nervous Benefit Period Limit must be coded and a positive integer. If no, should be blank.
19. If Other Diagnoses Benefit Limit Indicator is equal to “Yes” then Other Diagnoses Benefit Period Limit must be coded and a positive integer. If no, should be blank.
20. Gross Benefit Amount must be greater than 0.
21. Difference between Benefit Commence and Disability dates must be > Elimination Days – 30.
22. Difference between Benefit Commence and Disability dates must be < Elimination Days times two, or 30 if elimination days is 0.
23. If Diagnosis Code is equal to “Maternity” then Gender must be equal to “Female”. Diagnosis code is mapped from Icd9 codes 630 to 679 or 760 to 779 or V20 to V39 and mapped from Icd10 codes O00 to P96 and Z30 to Z39.

8 – New Audit Tests

The first three additional recommended tests address variables that were not part of the prior study. The last two are additional tests pertaining to the end of the exposure period (which had some issues in the prior study).

1. SS Award Date is earlier than Data Collection Date (9/30/2018).
2. SS Award Date is greater than the Date-of-Disability.
3. SS Award Date is earlier than the Liability-Termination-Date .
4. If Claim Status is equal to "Closed" with the closure type being a "Limit" then the Liability-Termination-Date must be within one month of the Limit-Date.
5. If Claim Status is equal to "Closed" with the closure type being "Maxout" then the Liability-Termination-Date must be within one month of the Claim-Maximum-Date.

As stated in a prior section, we do not require 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 issue:

- Sort the claim inventory by Social Security Number, disability date and paid-through-date.
- For claims with the same SSN and date of disability, determine whether 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).