Expert Views

Facts and Fictions on Disability Insurance

Deciphering the risk dynamics of disability products

SCOR
The Art & Science of Risk

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Introduction

Around the world, there are more than 3.6 billion people in the active labor force, according to the World Bank. Unfortunately, not everyone will have a smooth and safe work life from beginning to end. Many workers experience hardships at some time during their careers, regardless of efforts to prevent them. Aside from death, which is the most catastrophic event for individuals and their loved ones, becoming disabled due to sickness or injuries can have devastating physical, emotional, and financial effects.

Group income disability insurance products serve as a critical protection method to mitigate severe financial hardship when workers are not able to perform their jobs. The global disability insurance market is large and rapidly growing, estimated at approximately USD4.4 billion and expanding at a CAGR of 11.2% from 2024 to 2033.[1]

While insurers and reinsurers are committed to providing financial relief to the hardworking and honest workers who deserve adequate income protection during the disability period, there is also rising concern that could threaten group disability insurers - with experience potentially contrary to product expectations. There are many factors that are contributing to these assumptions. Are they solid facts or mere misperceptions?

In this article, SCOR's experts in income disability claims focus on the disability products within the group risk industry, aiming to distinguish between prevalent perceptions and empirical realities ensuring that our product terms and conditions are implemented as expected in practice. Using data from SCOR's data pool, we investigate two commonly debated problem statements to unveil whether they are fact or myth.

Fact or Myth #1: Increasing Difficulty Terminating Income Disability Claims after the Initial Period

Insurance claims experts tell us that it has become more difficult during the past few years to terminate income disability claims after the initial period. But is this true or is it a misperception?

To investigate this, let us start with the claims filing and disability determination process. To file a claim on a group disability income product, a potential claimant must meet the product's disability definition. In many countries, these products typically apply one definition during the first six, 12 or 24 months (called "the initial period"), followed by a different and stricter definition thereafter (called "the extended period").

During the initial period, claimants must usually be unable to perform their own occupation with either their own or any employer to qualify for a claim.

Thereafter, a claim is reassessed in the extended period against a different definition of disability. The most common definition applying in the extended period is the inability to perform your own or any reasonable alternative occupation, given the member's age, education, training, and experience with any employer.

Let us clarify this with an example: if a marketing actuary is required to travel for a large proportion of the job, becoming a paraplegic and being wheelchair-bound would mean that they would not be able to perform their own occupation, making them eligible for disability in the initial period.

1. *Disability Insurance Market Size to Hit USD 12.89 Bn by 2033*

After this initial period has passed, however, the insurer would reassess this claim. Depending on the claimant's age, it could be reasonable to propose that the claimant be reskilled and transition to a more technical role that requires no travel and can be performed by working remotely. In this scenario, the claim would be terminated upon the change of definition.

Figure 1 is the summary of the commonly found group income disability benefits and initial period duration from different countries.

Figure 1: Commonly found group income disability benefits initial and extended period definition by country

Country	Initial Period Definition	Initial Period Duration	Extended Period Definition
Germany	Own occupation		N/A
Netherlands	Own occupation		N/A
Sweden	Suitable work for their existing employer	180-365 days	Any job at normal labor market
South Africa	Own occupation	24 months	Own or any reasonable alternative occupation
Australia	Own occupation	24 months as an option	Any occupation for which they are reasonably qualified by education, training, or experience.
Canada	Own occupation	24 months	Any occupation
US	Own occupation	24 months	Any occupation

As previously stated, one of the prevailing notions in the insurance industry in many countries is that it has become more difficult to terminate income disability claims at the change of definition, even though the disability definition becomes stricter. Is this true or not?

The quick answer is: Yes, it's a general fact observed in many countries. The definition of disability in the extended period can be interpreted as relatively subjective, and defining what makes a reasonable alternative occupation could be challenging. Although the responsibility doesn't lie with an insurer to find a job for the claimant to terminate the claim, they must be able to show that there is a reasonably suitable job that the claimant could fulfill. As such, claims assessors are finding it increasingly difficult to apply the definition consistently, leading to them having to become occupation experts as well as medical experts. Their decisions are being regularly challenged, mainly by the claimants themselves.

Let us give you an example. In Canada, achieving a resolution within a year from the onset of disability is often considered the best outcome, as it typically indicates a successful recovery and return to normal activities. Once the period of disability is prolonged, it becomes difficult to support return-to-work initiatives and terminate the claim.

That said, if the claim continues to the point of definition change, this would be the best time for the claims assessors to reach a resolution proactively before or by the change of definition date.

For a claim to be terminated, the insured must be able to work in another occupation and earn a commensurate income, usually 66.67% to 70% of their pre-disability income. However, in the last few years, there has been a decline in claims termination in a timely manner due to a combination of multiple issues. One of the most pressing issues is the increased caseloads of claims assessors and reduced budgets, which makes it extremely hard for the assessors proactively to manage claims and use the appropriate tools, such as employing rehabilitation vendors or paying for therapy in all cases when necessary.

Another common issue is excessive delays in obtaining specialist consultations, treatment, and surgeries.

Another example is from South Africa. When we analyzed the observed termination rates of group disability income claims in this market, we found a clear spike in the termination rate near the 24-month mark, as shown in Figure 2. This indicates that the stricter disability definitions in the extended period are being applied, leading to fewer claimants remaining in force after the initial period. While this seems to counter the problem statement previously mentioned, it is worth noting that similar products in other countries observe far higher terminations at the end of the initial period.

Figure 2: Termination rate by duration

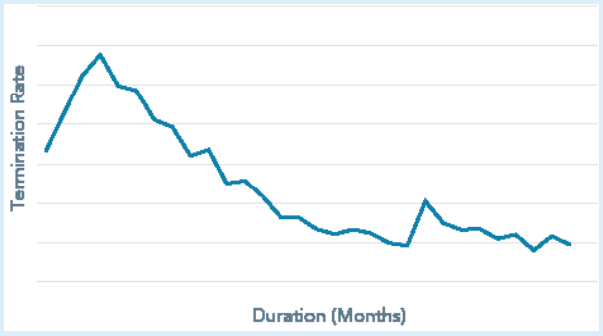
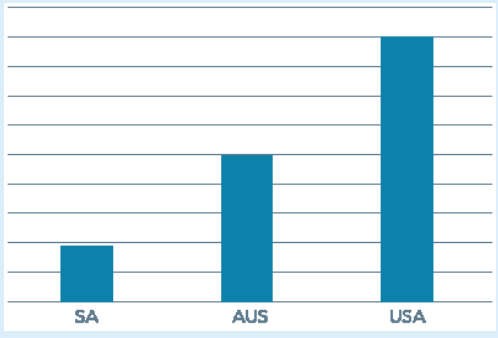


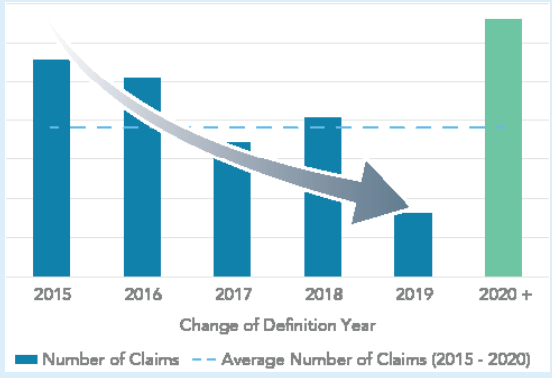
Figure 3: Number of claims terminated per 100 claims in force at the change of definition



In the US, the Society of Actuaries (SOA) Group Long-Term Disability (GLTD) studies indicate that the US termination rates exhibit a marked increase at the 24-month change of definition point, reflecting the transition from "own occupation" to "any occupation" criteria. The 2018 GLTD study shows that the last three termination studies have shown significant variations in the impact of the definition of disability in the months immediately after the change in definition. The GLTD2008 expectations show a significant increase in recoveries in the month of the change and then elevated, but declining expectations in the eight months after the change, although the pattern varies by carrier and reason for termination.

To assess if it is becoming more difficult to terminate income disability claims after the initial period, we analyzed the number of claims terminated per 100 claims in force in South Africa at the change of definition for claimants that fell under a 24-month initial period over the past few calendar years (Figure 4).

Figure 4: Number of claims terminated per 100 claims in force at the change of definition in South Africa



In Figure 4, we can clearly see a decreasing trend in terminations at the end of the initial period from 2015 through 2019. This suggests that it is becoming more difficult to terminate claims when the disability definition changes. As a result, more claims are staying in force at the beginning of the extended period over the observed period. The significant increase in 2020 and beyond reflects a general increase in termination rates at all durations during the COVID-19 pandemic, primarily due to COVID-19 excess mortality.

This data shows that South African insurers are terminating significantly fewer claims compared

to other countries at the change of definition. This may be attributed to low claimant motivation and limited reskilling opportunities amid the current high unemployment rate in the country. Furthermore, the findings suggest that insurers' effectiveness in terminating claims at the change of definition isn't as high as the product design initially intended, and it has even reduced over time. This suggests that the answer to our initial questions is: It's not a myth but a fact.

Australia is another example. In Australia, corporate group insurance disability income products typically feature an option to differentiate product terms after the initial period. The price differential between the options is relatively minor and therefore reflects that the expected increase in termination rates at the point in definition change is not significant.

The Australian retail industry experience study shows that for the 10-year period up to December 2018, claims' costs increased by 65% and the market sustained these losses. (KPMG & FSC, 2020). This can be attributed to the comprehensive and liberal policy conditions awarded to insured lives, particularly for income disability insurance. While Australian insurance products including group insurance were effective in managing short-term disability, they provide limited financial incentives to return to work for long-term conditions.

The Australian experience highlights how overly liberal policy conditions can be taken advantage of and threaten the very sustainability of disability income insurance business.

The eventual solution was provided by the Australian Prudential Regulation Authority (APRA). In December 2019, APRA made the decision to intervene in the Life insurance sector by introducing a range of measures to address the flaws in income protection product design and pricing that had resulted in industry losses. This regulatory intervention was welcomed by the Australian Life insurance market, as insurers had been reluctant to alter policy conditions that would have put them at a competitive disadvantage.

The Royal Australian College of Physicians and The Australasian Faculty of Occupational & Environmental Medicine reflect within their position statement that "the more time spent away from work, the less likely a person is to ever return." Experience shows that if you are off work for:

Days off work	Chance of you getting back to work
20 days	70%
45 days	50%
70 days	35%

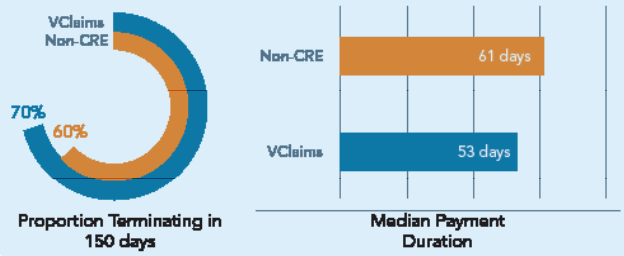
Overall, we can conclude that there is a gradual trend towards lower termination rates at the change of definition point across the markets over recent years, suggesting it has become harder to terminate claims. This trend is consistent with our findings in Canada, Australia, the United States, and South Africa, where economic factors, claimant advocacy, and legal frameworks increasingly impact the termination process.

How can insurers strengthen their ability to ensure that our product terms and conditions are implemented as expected in practice? One of the effective methods is to utilize the latest technology and innovation that assists in mitigating those risks, both on new and in-force claims.

SCOR's VClaims, an innovative digital platform designed to streamline and optimize the claims management process, is one such tool. It aims to make filing and processing claims as stress-free and efficient as possible. Simple claims can be automated or assigned to certain employees for fast-tracking, while complex claims can be assigned to assessors based on their experience and strengths. This will enable insurers' claims teams to concentrate resources for focused and proactive work to reduce claim durations.

Early indication shows that VClaims has appropriately expedited claim terminations within 150 days by 10% and reduced payment periods by eight days.

Figure 5: VClaims vs. non-CRE claims performance (Source: SCOR)



Fact or Myth #2: No Pricing Impact of Reducing or Removing the Deferred Period for Total & Permanent Disability

Now let us move on to Fact or Myth #2. Some industry experts say that reducing or removing the deferred period for Total and Permanent Disability (TPD) shouldn't have a pricing impact since permanency needs to be established. Is this true, or is it just a misperception?

Group TPD products pay a lumpsum benefit when a member is unable to work due to a total and permanent disability after an illness or injury where there is no prospect of recovery. Benefits are often contingent upon the member's survival and their continuous disability throughout a deferred period.

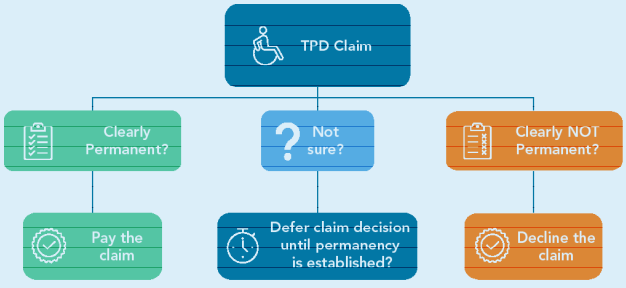
Although there are a variety of ways in which being "unable to work" can be defined, a common underpin is that the member must be permanently and totally incapable of returning to work.

These products are commonly sold as standalone products in many markets, such as Australia and South Africa. However, in some other markets such as Germany, Sweden, Netherlands, and Canada TPD products are seen as rare riders.

Questions often arise about the relevance of deferred periods for TPD products because of the permanency requirement. The more specific question would be: would reducing or removing the deferred period for TPD products have any pricing impact?

Figure 6 shows a simplified decision tree for assessing TPD claims in the group market.

Figure 6: Decision tree for assessing TPD claims in the group market



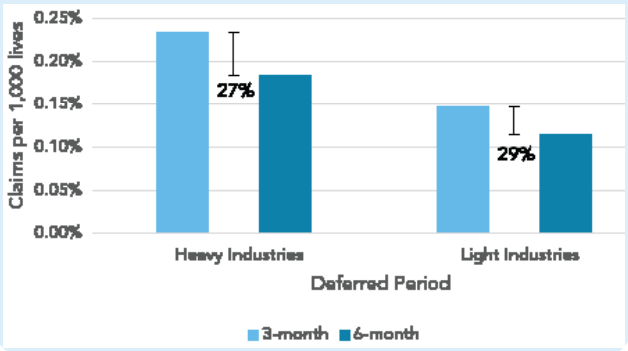
A valid TPD claim would be paid after the deferred period (if one exists) where it has been confirmed that the claimant is totally and permanently unable to perform either their own or any occupation as

defined in the policy. Some insurers may choose to pay these claims before the end of any deferred period.

For claims where assessors cannot immediately establish permanency, the claim decision would be deferred until such time as permanency can be established (or refuted). Different claims conditions would require a different amount of time to manifest and determine permanency. Claims that clearly do not meet the definition of disability would be declined. Given this assessment process, the claims trigger relies on establishing permanence rather than completing the deferred period. One could argue then, that the deferred period on TPD products serves less of a purpose and should not lead to a pricing differential.

So, what does our data tell us? We analyzed the experience of group TPD products in South Africa, split into two categories – heavy and light industries – to compare the experience for three- and six-month deferred periods. Results shown in Figure 7 illustrate a clear difference between those two periods in claim incidence rates a 27% difference for heavy industries and a 29% difference for light industries.

Figure 7: PTD Claims per 1,000 Lives (Source: SCOR Internal)



One possible explanation for this difference could be mortality risk. Although we wouldn't normally expect mortality to be significant over the course of a few months, it is possible that those claiming TPD could exhibit substantially higher mortality than usual. If a claimant passes away during the deferred period, they would not be eligible for the benefit payout. Thus, longer deferred periods could show lower incidence because of mortality during the deferred period.

On the other hand, many assessors consider TPD claims to be among the most complex claims to assess. The capability and expertise of claims assessors is critical in determining validity of TPD claims. Could it be because we have more non-permanent claims at the end of shorter deferred periods?

In the group risk environment, this could be heightened by pressure from the claimant, employer, and broker to finalize the claim once the deferred period has expired. The shorter time period would also limit the quality of the information obtained from treating medical practitioners who would not be skilled in assessing permanence in the context of life insurance definitions. In addition, perhaps shorter deferred period products offer a shorter time frame for claims assessment, which could potentially reduce the accuracy of the claim assessment and could result in a range of outcomes depending on the quality of the insurers claims assessment capability.

Many Australian superannuation funds (retirement trust) and insurers have included retraining clauses in their TPD policies. This means that to qualify for a TPD payout, claimants must demonstrate that they cannot perform their usual job or any other job within their education, training, and experience, and that they cannot be retrained for a new job within reason. When assessing claims with retraining clauses, insurers consider factors such as the availability and cost of retraining programs, the claimant's ability to successfully complete the training, and whether the training would realistically lead to re-employment.

These clauses have helped reduce the number of admitted TPD claims by encouraging claimants to pursue rehabilitation and retraining opportunities. This approach not only helps individuals return to work but also reduces the financial cost of

the insurance provided through the fund. This shift towards rehabilitation and retraining has been a positive development, promoting a more sustainable and supportive approach to managing disability claims and placing less reliance on claimants meeting the deferment period criteria. The definition of TPD plays an important role to enable claims assessors to consider these criteria and improving the determination of permanence.

In light of this analysis, we can conclude that the answer to Myth or Fact #2 is indeed a myth. Reducing or eliminating the deferred period does indeed impact pricing, even across different industry segments. This result, or at least the magnitude of the impact, can have different outcomes based on industry, product definitions, and individual insurers.

Closing Thoughts

Navigating the complexities of disability products within the group risk industry requires a nuanced understanding of how policy definitions, claimant experiences, and market dynamics interact.

Our analysis highlights those common perceptions - such as the increasing difficulty of terminating disability claims at the change of definitions and the notion that deferred periods have no pricing impact - often conflict sharply with the empirical realities.

As we move forward, it is imperative for actuaries and claims teams to foster collaboration, enhancing their collective insights to ensure product design remains robust, equitable, and responsive to the evolving landscape. By bridging the gap between analytical rigor and real-world application, we can continue to refine our understanding and management of disability risk, ultimately leading to better outcomes for the insurance industry and claimants.

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