

U.S. Department of Labor
ERISA Advisory Council

Meeting on:
Thursday, September 21, 2023
C5320, Room 6, Frances Perkins Building, Washington, D.C.

Long-Term Disability Benefits and Mental Health Disparity

Statement for the Record by Bridget Bearden, Ph.D.
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My name is Bridget Bearden, Research and Development Strategist at the Employee Benefit Research Institute (EBRI). Thank you for inviting me to testify before the ERISA Advisory Council (“the Council”), on the topic of mental health disparity and long-term disability insurance benefits. The COVID-19 pandemic and its mental health aftermath has put a spotlight on the need for employer-provided mental health benefits as well as the flexibility for traditional workplace benefits to incorporate the rapidly increasing prevalence of mental illness more fully.

EBRI’s mission is to produce and communicate independent, objective, nonpartisan data, research, and other information about employee benefits. Our work supports employers, policymakers, service providers, and others in developing innovative solutions and making policy and design decisions.

This testimony draws upon multiple data sources, including publicly available data from the National Compensation Survey from the U.S. Bureau of Labor Statistics and the American Community Survey from U.S. Census Bureau, proprietary survey sets including the EBRI/Greenwald Workplace Wellness Survey and the EBRI/Greenwald Retirement Confidence Survey, and new qualitative research with employers and benefits brokers. We hope the Advisory Council finds this mixed-methods approach helpful in their deliberations on the topic.

This testimony is structured as follows: First, I will address the prevalence of disability among Americans and among the employee population. Next, I will address the state of mental health in the workplace, and then access to and uptake in employer-sponsored long-term disability insurance programs. I will conclude with the intersection of mental health and disability insurance benefits based on qualitative research conducted in preparation for this testimony.

According to the American Community Survey (ACS), as of 2021, 42.5 million Americans of all ages have a disability, or 13 percent of the civilian non-institutionalized population.ⁱ While the survey shows that only 11 percent of working age adults aged 18–64 have a disability, we also understand that the prevalence of disability increases with age, as 33 percent of civilian Americans ages 65 and over have at least one disability [Figure 1].

The American Community Survey, the Survey of Income and Program Participation, and the Current Population Survey use a six-item set of questions to gauge disability.ⁱⁱ Survey respondents may select multiple types of disabilities within the survey. The six disability types are:

1. Hearing difficulty — Deaf or having serious difficulty hearing.
2. Vision difficulty — Blind or having serious difficulty seeing, even when wearing glasses.
3. Cognitive difficulty — Because of a physical, mental, or emotional problem, having difficulty remembering, concentrating, or making decisions.
4. Ambulatory difficulty — Having serious difficulty walking or climbing stairs.
5. Self-care difficulty — Having difficulty bathing or dressing.
6. Independent living difficulty — Because of a physical, mental, or emotional problem, having difficulty doing errands alone such as visiting a doctor’s office or shopping.

Naturally, not all these individuals are employed in the labor force. As of 2021, ACS estimated that of the 145 million individuals in the labor force, 8.7 million (5.99 percent) had some kind of

disability [Figure 2]. Since 2019, there has been a 10 percent increase in the number of the employed population with a disability.

Of those disabled in the workplace, the most frequently reported type of disability is cognitive, at 38 percent. In 2018, cognitive difficulty surpassed ambulatory difficulty as the most reported disability in the employed population [Figure 3]. Since 2019, there has been an 18 percent increase in the number of employees with a cognitive disability.

While we understand this definition of cognitive difficulty may be different than other definitions of mental health issues, it is an important context when we turn to the mental well-being of workers. In the 2022 EBRI/Greenwald Workplace Wellness Survey, we learned that 4.7 percent of workers report emotional well-being/mental health as “poor,” and 13.7 percent report their emotional well-being/mental health as “fair” [Figure 4]. In total, this amounts to just over 18 percent, or nearly 1 in 5, who say their mental health is worse than “good.”

The 2022 EBRI/Greenwald Retirement Confidence survey found a similar prevalence of total respondents (including both workers and retirees) who reported a mental/emotional health of fair or poor, at 19 percent (approximately 1 in 5 respondents).

Mental illness impacts both current financial security and expectations of future financial security. Using the measure of retirement confidence, or their ability to have enough money to live comfortably throughout retirement, in 2022 we found that across our entire sample, about two-thirds said they were somewhat or very confident in their retirement prospects. [Specifically, 29 percent of individuals surveyed felt they will have enough money to live comfortably through retirement, and 35 percent were somewhat confident.] Just under 1 in 10 (9.5 percent) of respondents were not at all confident that they would have enough money to be comfortable throughout retirement.

However, when we segment by self-reported mental health status, we find that mental health has a substantial impact on an individual’s retirement confidence. Across workers and retirees, lack of confidence in having enough money to live comfortably throughout the retirement years increases as self-reported mental health declines [Figure 5]. Whereas 92 percent of those with “excellent” self-reported mental health were very or somewhat confident, only 43 percent of those with “fair” self-reported mental health were very or somewhat confident, and only 15 percent with “poor” self-reported mental health were very or somewhat confident.

Having addressed the prevalence of disability related to cognitive difficulty broadly and in the workplace, and the impact of mental health status on retirement confidence, I turn now to access and participation in long-term disability insurance.

In setting the stage, based on the National Compensation Survey — a survey of business establishments — we find that access to long-term disability insurance benefits has increased 3 percentage points in private industry over the last 10 years [Figure 6]. Like access to retirement and health benefits in the private sector, we find differences in access to long-term disability benefits according to employer size [Figure 7]. Employers with more than 500 employees are three times more likely to offer long-term disability as compared with employers with less than

50 workers. At the same time, we observe that the largest increase in offering of long-term disability insurance since 2010 (22 percent) is among employers with less than 50 workers. We also observe differences in access to long-term disability programs based on employment status, where full-time workers have greater access to the benefit than part-time workers [Figure 8].

Having established the baseline statistics on the status of mental health in the workplace and the availability of long-term disability insurance benefits, now I will turn to the intersection of mental health and long-term disability.

Whereas the National Compensation Survey gauges employer-reported access to benefits, the EBRI/Greenwald Workplace Wellness Survey tracks worker awareness of being offered the benefit. In 2022, we found that 56 percent of workers reported having access to a long-term disability policy. Yet, as we see uneven awareness on access to employer-sponsored benefits by employer size, employment status, and sociodemographic characteristics, we also observe differences in access to long-term disability insurance by mental health status. We find higher rates of low mental health status among those who are not offered or do not know whether they are offered long-term disability. Specifically, 13 percent of employees who are offered long-term disability insurance reported “fair” or “poor” mental health status, 25 percent of employees who are not offered long-term disability insurance self-reported their mental health status as “fair” or “poor,” and 27 percent who don’t know whether they are offered long-term disability insurance self-reported their mental health status as “fair” or “poor.” Taken another way, 60 percent of employees with fair/poor mental health are not offered or do not know whether they are offered long-term disability insurance.

Among those with access to long-term disability insurance, 56 percent are enrolled in, or participating in, the benefit, though not necessarily making a claim on the benefit. With respect to uptake by mental health status, while more research on benefits optimization and adverse selection is needed, the data in the 2022 EBRI/Greenwald Workplace Wellness Survey suggest a curved uptake, where self-reported “excellent” mental health indicates a 66 percent uptake, “good” is a 44 percent uptake, and “poor” is a 65 percent uptake [Figure 9].

Notably, the EBRI/Greenwald Workplace Wellness Survey does not distinguish among the various designs of long-term disability insurance benefits, such as ERISA status, funding strategy, or the level of employee contribution. These designs likely have an impact on employee uptake of the benefit.

When we ask employees who have any kind of disability insurance whether they believe they have enough coverage to protect against potential financial risks, 61 percent say they have enough coverage, 26 percent say they do not have enough coverage, and 13 percent do not know whether they have enough coverage. Notably, the percentage of employees who report they have enough coverage decreases as self-reported mental health status declines. Naturally, it follows that even when employees with “poor” or “fair” self-reported mental health are asked whether the disability benefit offered by their employer contributes to their feeling of financial security, they are less likely to agree than those with stronger mental health statuses.

The last component of this testimony draws upon qualitative insights gained from interviews with benefits brokers and employers on long-term disability benefit design. Here we use a

qualitative approach. It's important to note that while EBRI fields surveys and collects proprietary data, we also have access to certain anonymized administrative datasets, including 401(k), individual retirement account (IRA), health savings account (HSA), and health care claims. However, EBRI does not have access to a representative sample of group disability insurance claims data for empirical analysis. Given this data limitation on group insurance claims, we conducted interviews with benefits brokers and employers in preparation for this testimony. Our summary observations from these interviews are as follows:

- There is inconsistent terminology used on mental health limitations among employers, their benefits consultants, and insurance providers. This is also evident in differing terms among policies and diagnostic codes relative to mental health, behavioral health, and substance abuse in claims reporting. As with any employee benefit, a lack of a standard lexicon can complicate the decision-making process and impede innovation.
- Despite the lack of standard terminology, mental health issues are a common primary diagnostic code for long-term disability claims. Benefits brokers shared that mental health claims are often in the top-five diagnostic categories for long-term disability insurance claims.
- Common duration limitations for mental health and substance abuse claims are typically 24 months, which appears to be standard default language in most long-term disability policies. Employers can negotiate and customize this duration limit, but the prevalence of this customization depends on employer size and industry, use of a broker, awareness, and resources, among other constraints.
- Comorbidities, causality (whether mental health issues arise because of another disability), and whether the disability results in a total loss of ability to work are additional important considerations that often require subjective review relative to job responsibilities and policy description.

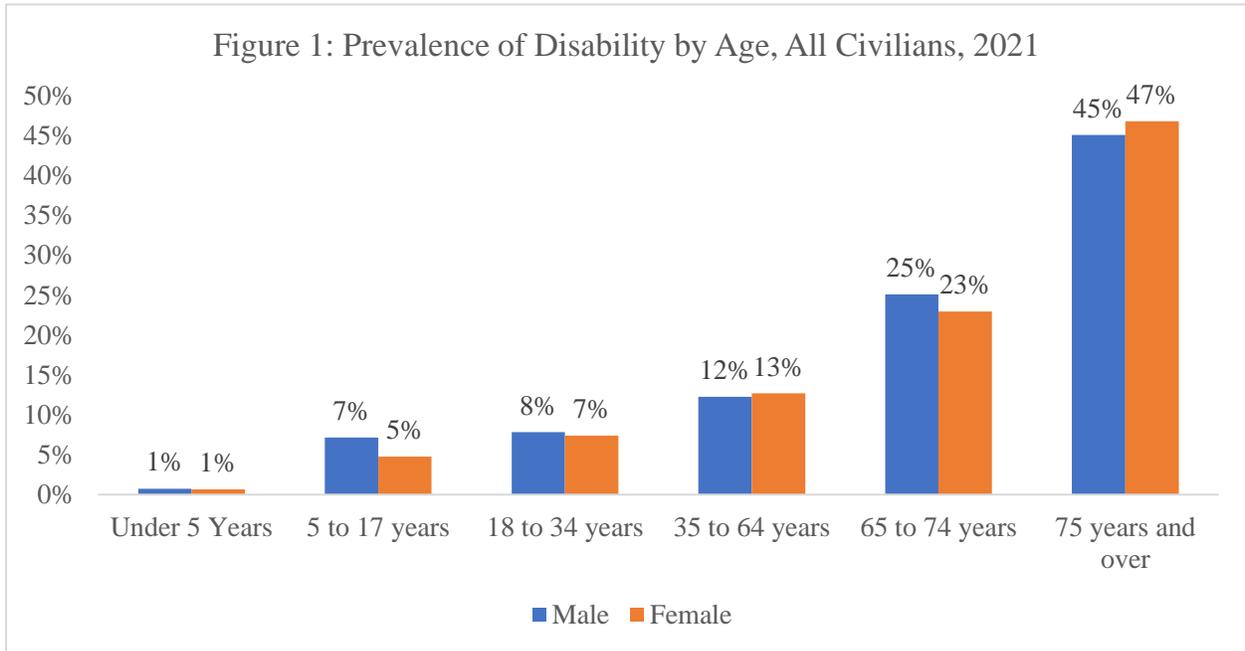
We also received anonymized input from nearly a dozen benefits decision-makers at large employers who are very familiar with the disability insurance design of their organization. In aggregate, these employers represented over 300,000 employees across different industries. Given the small sample, the results should be interpreted as qualitative to inform further research and not representative of all employers. Our summary observations among those we spoke with are as follows:

- Ten of the 11 employers that took the survey offered a long-term disability insurance benefit plan subject to ERISA. For these employers, the most common funding strategy for long-term disability insurance benefits was fully funded/fully insured.
- Six of the ten with plans subject to ERISA indicated that disability income benefits can continue until retirement age regardless of reason for disability (illness, injury, medical, mental, substance use, etc.). Four of ten indicated that certain disability benefits were subject to duration limit of 24 months.
- Among those that had a duration limit, most (three) reported that mental health conditions applied to the limit. One employer indicated that pre-existing conditions also applied to the duration limit.

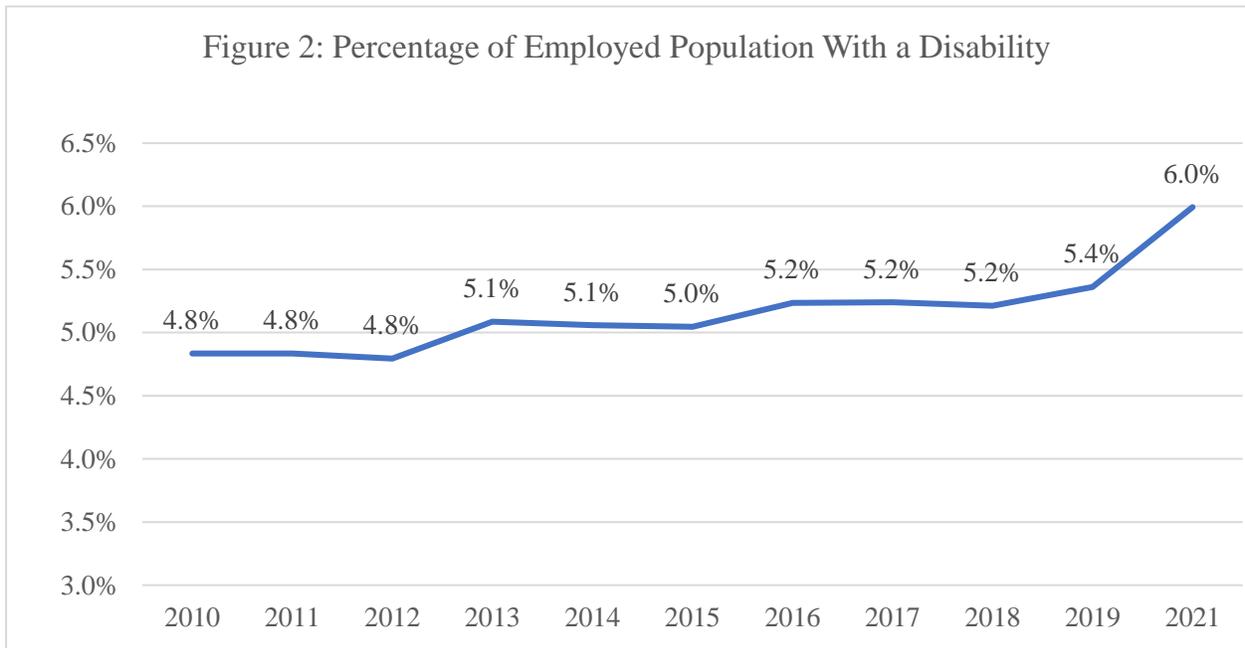
- Generally (eight in ten) employers paid the full cost of the long-term disability coverage, and employee contributions were not required for the long-term disability insurance premiums.
- Five of the 11 employers surveyed were planning to make changes to their long-term disability insurance benefits in the next 12 to 24 months. These changes included carrier changes and making the benefit fully employer paid. Some employers that do currently impose a duration limit on mental health conditions indicated they are reviewing these limits, including increasing or removing duration limits for mental health.

As concluded in other EBRI research, a significant number of Americans suffer from mental illness or a substance use disorder each year, and while the COVID-19 pandemic has exacerbated such issues, it also heightened employers' awareness and response to employees' mental health disorders.ⁱⁱⁱ The connection between disability, health, and wealth benefits is increasingly clear, as well as the connection between mental, physical, and financial wellbeing. EBRI applauds the Council's inquiry into mental health disparity and long-term disability benefits. We look to be of support as employers, industry providers, and policymakers develop comprehensive and integrated benefits programs to address holistic wellbeing.

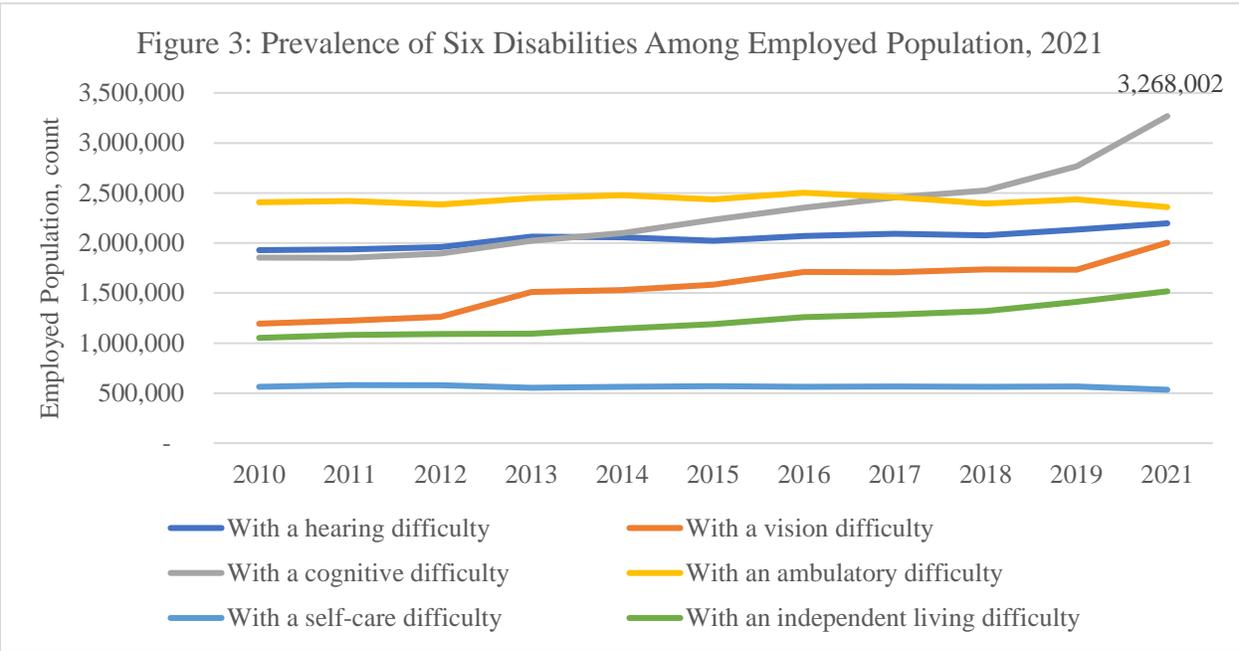
Appendix: Charts



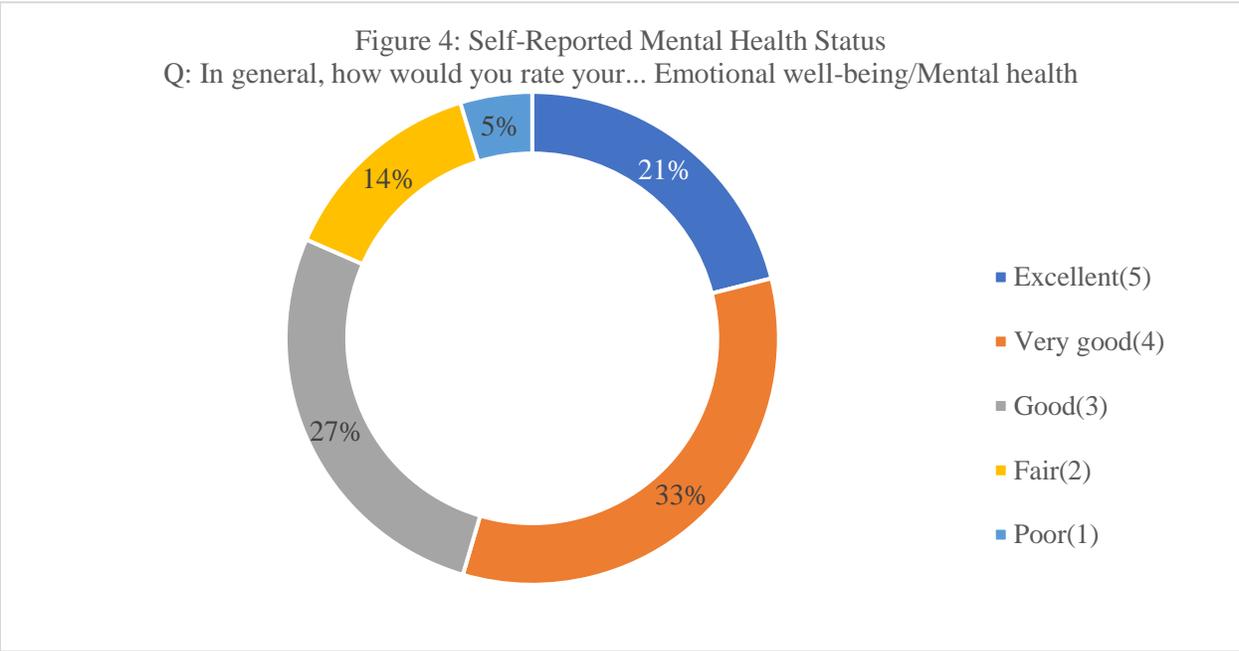
Source: EBRI analysis of United States Census Bureau. American Community Survey.



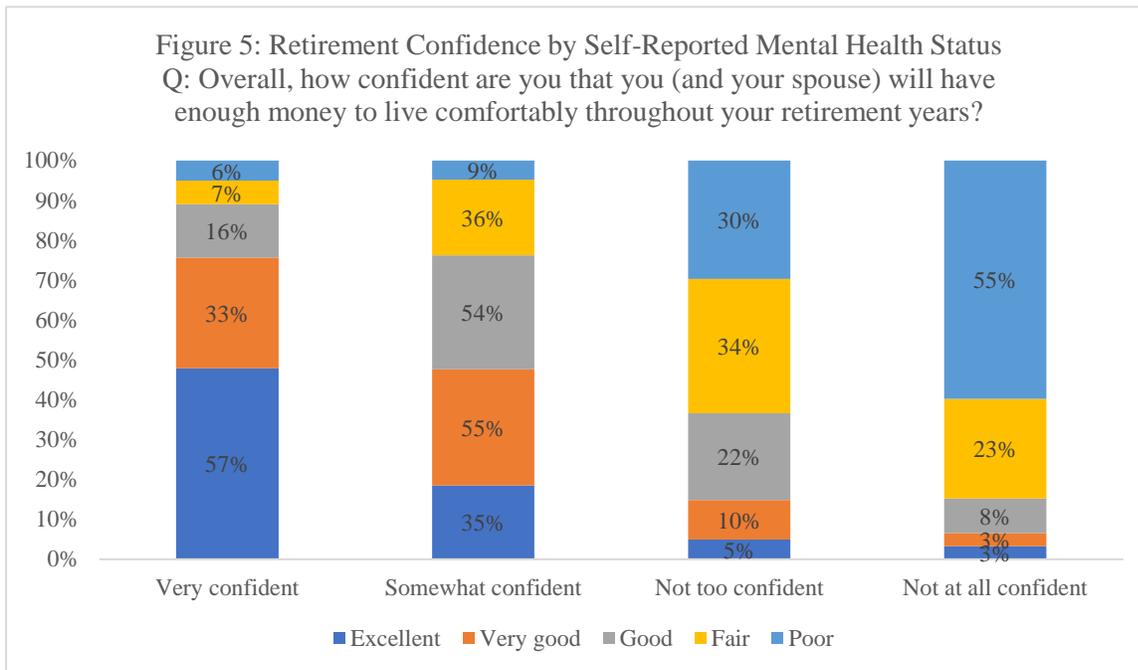
Source: EBRI Analysis of United States Census Bureau. American Community Survey.



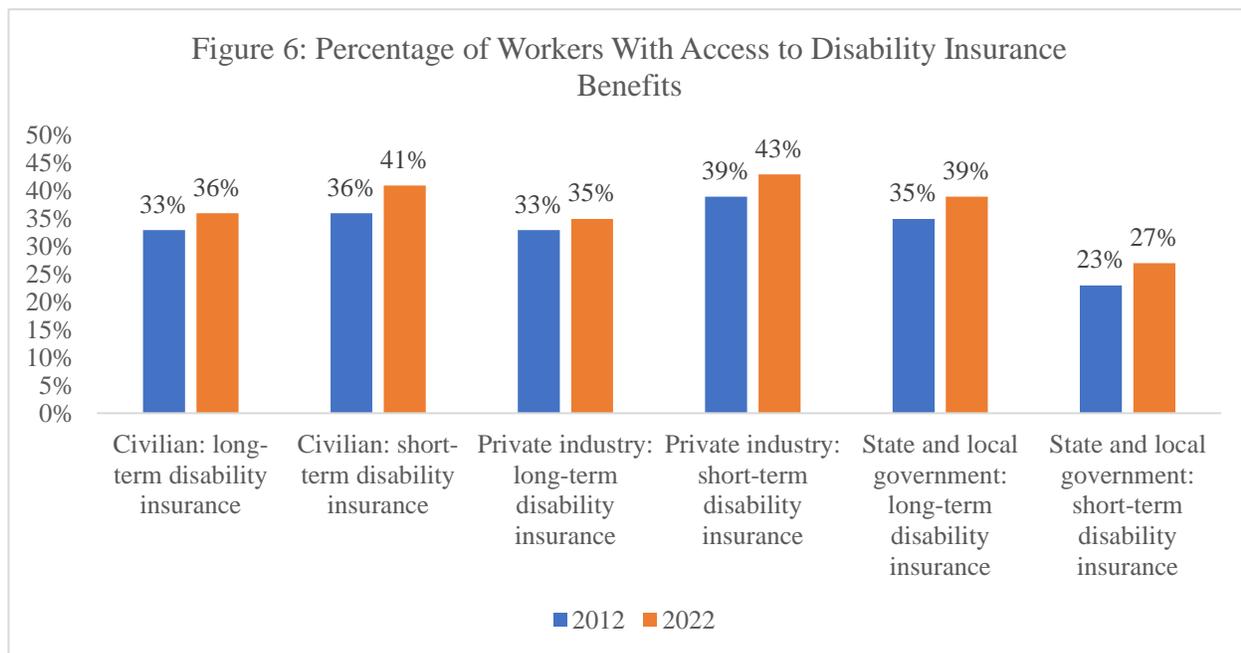
Source: EBRI Analysis of United States Census Bureau. American Community Survey.



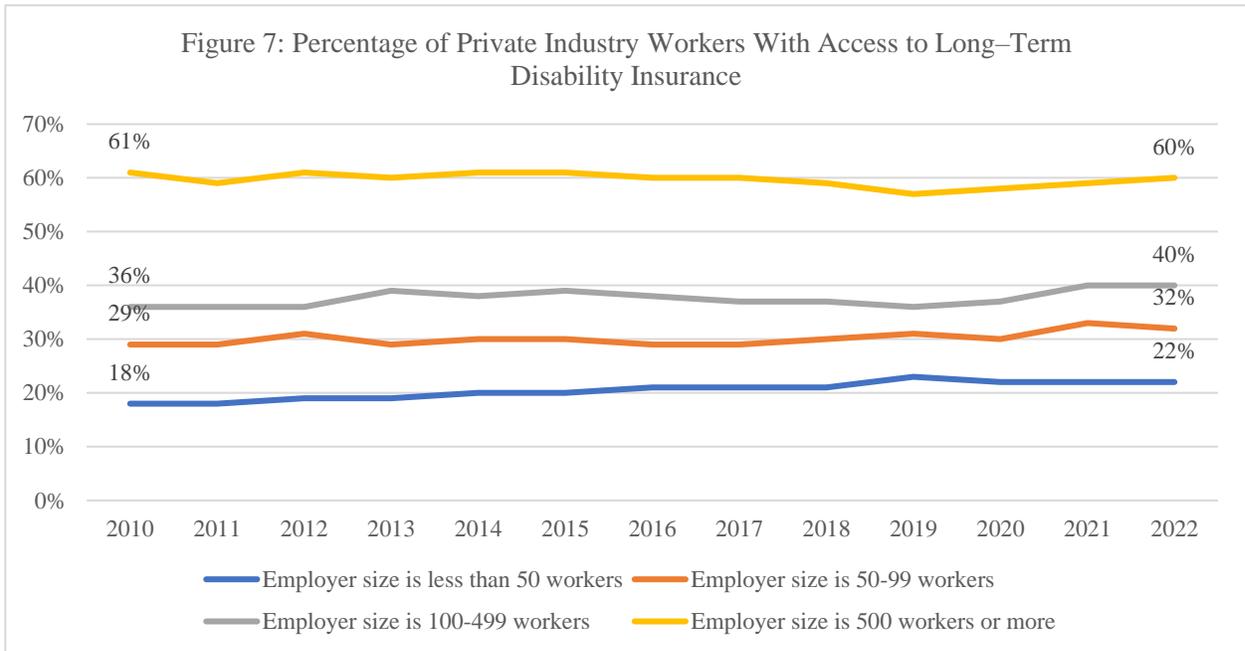
Source: 2022 EBRI/Greenwald Workplace Wellness Survey



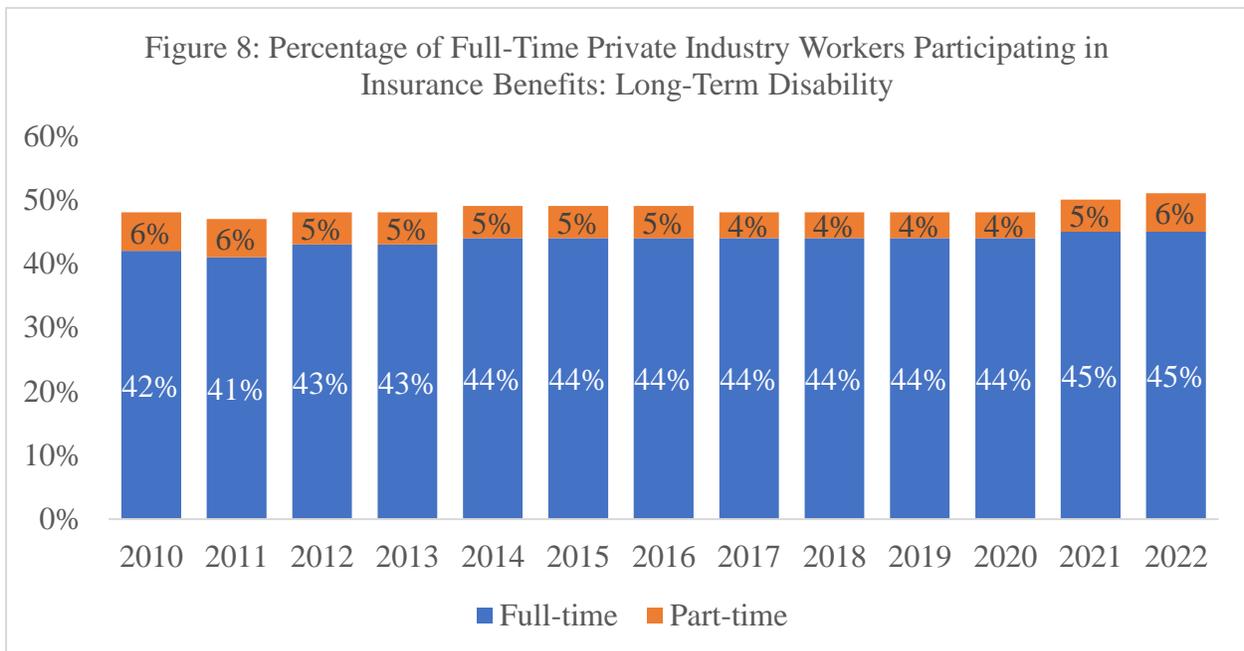
Source: 2022 EBRI/Greenwald Research Retirement Confidence Survey



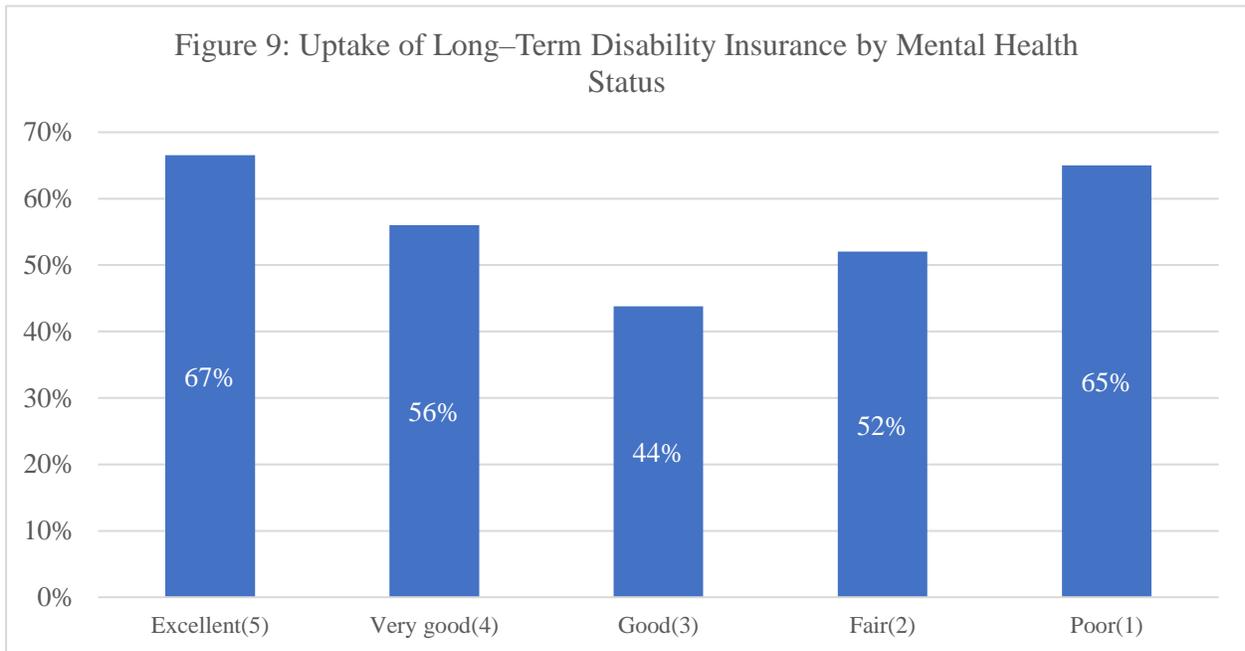
Source: U.S. Bureau of Labor Statistics, National Compensation Survey (NCS)



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Source: 2022 EBRI/Greenwald Workplace Wellness Survey

ⁱ U.S. Census Bureau, American Community Survey. 2021 ACS 1-Year Estimates. S1810 Disability Characteristics. Total Civilian Noninstitutionalized Population.

ⁱⁱ U.S. Census Bureau, How Disability Data are Collected from The American Community Survey. <https://www.census.gov/topics/health/disability/guidance/data-collection-ac.html>

ⁱⁱⁱ Fronstin, Paul, and M. Christopher Roebuck, "Use of Health Care Services for Mental Health Disorders and Spending Trends," *EBRI Issue Brief*, no. 569 (September 8, 2022).