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Critical Illness Insurance in Canada

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Critical Illness insurance goes by many names: Dread Disease in some locales, Chronic Care, Trauma Care, and "Maladies Grave" for the French speaking. All sound very ominous, but the origins are much more positive. The product was first developed in 1983 by a South African heart surgeon, Dr. Marius Barnard who famously said "you need insurance not only because you're going to die but because you're going to live!"

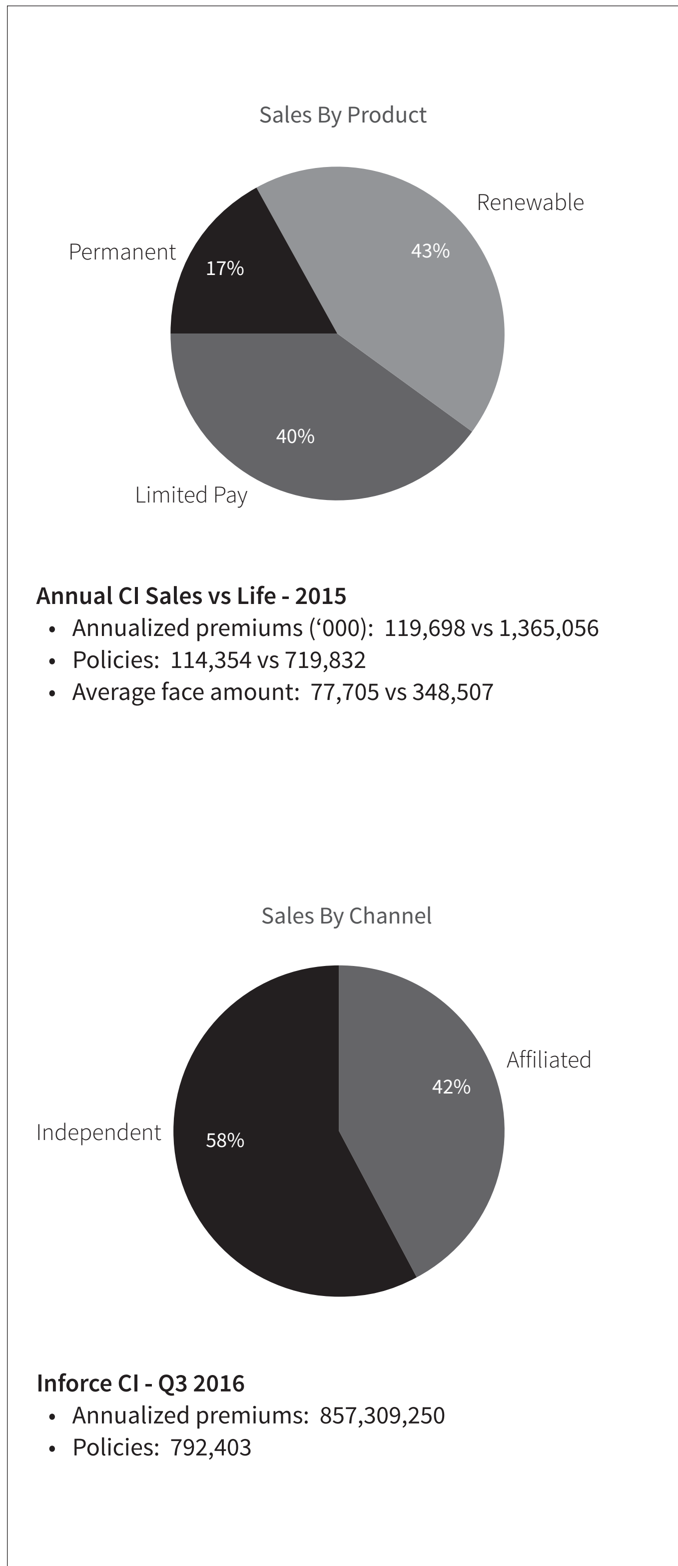
Dr. Barnard was a member of a team (led by his brother Christian Barnard) that performed the first heart transplant in 1967. Dr. Barnard, to his dismay, watched his patients suffer the subsequent stress of financial hardship during recovery rather than celebrate survival. He became passionate about the reality that medical advancements could not be meaningful unless the issue of financial security was also addressed. He looked to South African life insurers for a solution and in 1983, the first Critical Illness (CI) product was born.

The first product sold by Crusader Life covered 4 conditions—heart attack, cancer, stroke and coronary artery bypass graft. The product quickly gained popularity and expanded to the U.K. and Israel in 1986, followed by Australia and North America in the late 1980s, and the rest of the world in the 1990s. Critical Illness is now sold in more than 50 countries around the world. Figure 1 shows the magnitude of sales by country. More than half the CI premiums are from Asia, with a large proportion from Japan where cancer policies are still very popular.

The product has had success in different forms depending on the market and how the sales are positioned. In the U.K., acceleration products on mortgage insurance are by far the most popular. Acceleration products are also very popular in Australia but not necessarily tied to mortgages. Canada has had more success with the stand-alone version where it is marketed to cover medical expenses. Standalone cancer policies have been around for a long time and represent a large proportion of the U.S. market (inforce) as well as Japan. More comprehensive standalone products haven't really taken off in the U.S. where sales are mainly through worksite marketing and group plans. However, combination products with CI and LTC riders have become popular in recent years.

Figure 1
Critical Illness Sales around the World

Figure 2
Canadian CI Sales



CANADIAN MARKET

Critical Illness products first emerged in Canada as accelerated benefit riders in the early 1990s. The accelerated design never really took off due to uncertain tax treatment. The stand-alone version quickly took over popularity by the mid-1990s. There is a substantial creditor market and a smaller group market for CI. Some companies have introduced simplified issue products with fewer conditions (four to five).

The product has been successful but still accounts for less than 10 percent of life premiums. The products are sold at the lower face amounts, with an average size of only $77,000. As of Q3-2016, there was $857 million critical illness insurance inforce on 792,403 policies (see Figure 2, excludes creditor and group). New sales in 2015 were $120 million by premium and $8.3 billion by face amount on 119,698 policies.

Figure 3 shows that sales grew about 8 percent per year from 2008 to 2011. There was a 16 percent spike in 2012 just prior to price increases to account for low interest rates and the lingering effects of the 2008 financial crisis. Sales growth as a result was negative in 2013, flat in 2014, but the momentum has started to pick up again with growth rates returning to 8 percent in the last couple of years. We've seen more price competition recently as the financial markets have recovered and companies reduce rates to maintain market share.

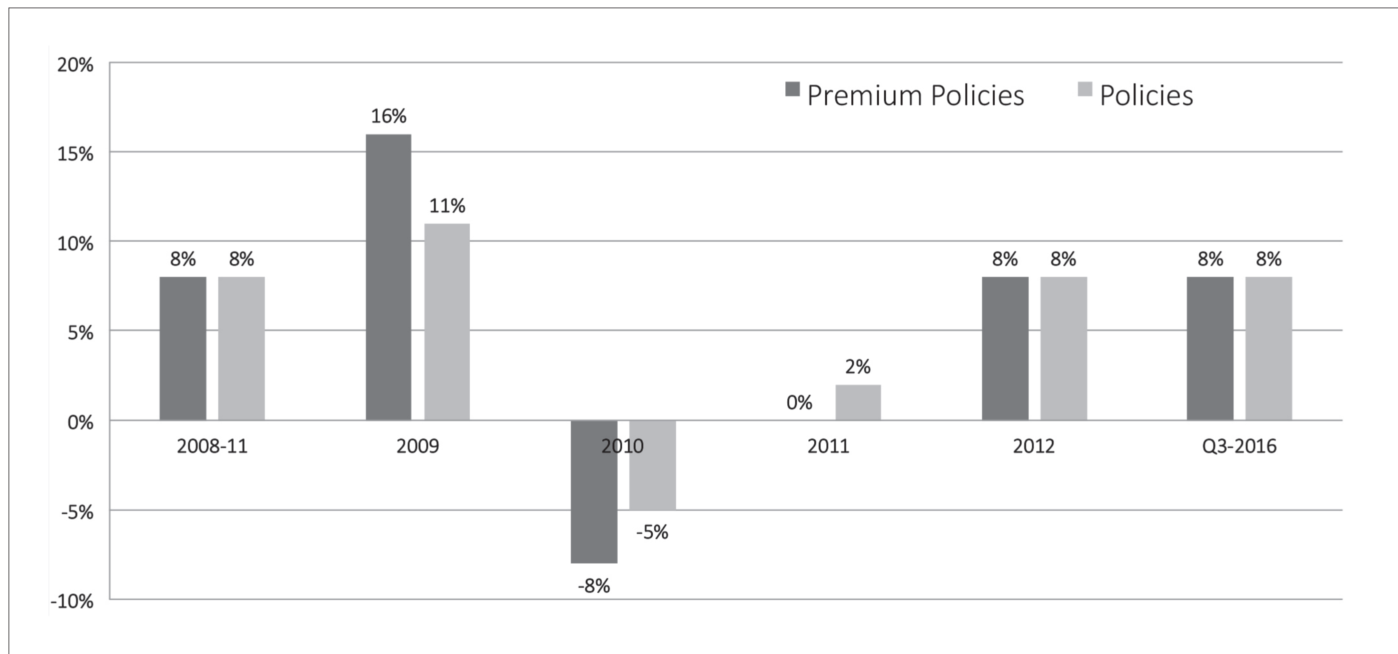
Most life insurers in Canada now have a CI product in their portfolio and about 15 companies are actively selling stand-alone CI. The top five writers account for 80 percent of total sales. The primary product platform in Canada is Level Term insurance. As shown in Figure 2, 43 percent of the products issued today are renewable Level Term (T10 and T20 are most common). After the initial level term these products renew to a higher renewable scale. Limited Term plans (Term to 65 and Term to 75) have become very popular now accounting for 40 percent of total sales, and Term to 100 plans account for the remaining 17 percent of sales.

COVERED CONDITIONS

CI insurance has evolved since the first product launched in South Africa with four conditions. There has been intense competition over the number of covered conditions with some countries including more than 100! Competition on the number of definitions stabilized in Canada about a decade ago to about 25 conditions. The original four conditions still cover the great majority of the claims and adding more remote conditions is sometimes more marketing than improved coverage.

As the number of conditions and the number of companies selling CI grew, so did the customer confusion as to what was actually being covered. This led to mistrust of advisors and

Figure 3
Critical Illness in Canada - Growth Rates



issues at claims time. This eventually led to an industry wide focus on the standardization of definitions.

The Canadian Life and Health Insurance Association (CLHIA) published standardized definitions for 26 covered conditions for the first time in 2007. Most companies have adopted the standardized wording and include between 23 and 26 of the benchmark conditions. This has created stability in the market and confidence in the product. This facilitates the comparison of products across companies and simplify the sales process. These definitions were updated late in 2013. A few companies have since adopted these updates.

PRODUCT FEATURES

There is very little variation across products in Canada in terms of design and features and this consistency has contributed to its success. Three product features in particular have contributed to positive sales trends—standardized definitions, return-of-premium (ROP) riders and guaranteed rates.

Most products include 23 to 26 of the CLHIA conditions and most follow the exact benchmark wording. Most standalone products are non-cancellable so the covered conditions and the premiums are guaranteed for the duration of the contract. Multiple coverage is not as prevalent in Canada as it is in other markets. At this time there is only one payout on diagnosis of a covered condition. The exception is the "early discovery benefit"

> 85% of Female claims are for cancer and 61% for Males.

which pays a small amount for conditions that are less critical. There is a fairly standard list of four to six conditions typically included (e.g., angioplasty and early prostate cancer). The benefit ranges from 10 to 25 percent of the base face amount up to a maximum of $25,000 or $50,000. The payout does not reduce the base face amount.

Most plans include a 30 day waiting period to receive benefits and most include an exclusion for claims during the first 90 days for cancers and benign brain tumors. The maximum face amount in the Canadian market is $2 million and the maximum issue age is 65. Most products terminate at attained age 75 with the exception of Term to 100 which provides coverage for life. Conversion to longer term plans is offered on the Renewable Level Term plans. Typical riders are WP, ADB, loss of independent existence, children's term rider, LTC conversion rider. ROP riders are by far the most popular with a very high take up rate of more than 70 percent.

The ROP feature is a key component of most plans and a significant driver of sales in Canada. There are three versions—ROP on Death (ROPD), on surrender (ROPS) and on expiry of the

policy (ROPX). ROPD is offered on most plans and is often included in the base plan. ROPS is an optional rider offered on the permanent plans (T65/75) but is not included on level term products. The most common structure is to refund less than 100 percent of the premiums for surrender at the end of the 10th (or later) policy anniversary and 100 percent by duration 15 or attained age 65/75, if the insured has not claimed for a critical illness. ROPS is very attractive to the consumer in a low interest rate environment since the policyholder gets a refund of past premiums including the rider and essentially receives CI protection for "free."

Juvenile plans are often issued as stand-alone coverage in Canada and include the base adult conditions plus five or more "child" conditions. The product is available to issue ages 30 days to 17 and the policy expires at age 25. The maximum face amount is $250,000. Canada has quite a robust juvenile market compared to other markets. The U.K. market, for example, does not recognize an insurable interest on juveniles and most sales are in the form of a rider for much lower amounts.

PRICING ISSUES

The CI market is quite stable in Canada but there are challenges. Consistently low interest rates have resulted in many

Figure 4
Canadian Industry CI Experience Studies (expected basis 2008 CANCI tables)

Study Date	Feb 2013	Dec 2014	Oct 2016
Obs Years	2002-2007	2003-2011	2005-2014
Expected Basis	2008 CANCI	2008 CANCI	2008 CANCI
# Claims	1800	5000	7489
# Contributing Co's	7	10	11
Total A/E	57.7%	54.2%	52.0%
Male	57.4%	51.4%	48.8%
Female	58.3%	58.2%	56.6%
Band:			
<50k	43.6%	58.9%	49.6%
50-99k	55.1%	52.0%	50.5%
100-249k	57.9%	54.3%	52.6%
250k+	64.5%	57.6%	52.7%
Total	57.7%	54.2%	52.0%
Duration:			
Year 1	32%	29%	25%
Year 2	52%	50%	46%
Years 3+	70%	60%	56%
Implied UW Selection Factors:			
Year 1	46%	48%	46%
Year 2	74%	83%	83%
Year 3+	100%	100%	100%

carriers raising premium rates around 2012–2013. Some of the smaller companies still have not repriced their CI products and will likely have to do so in the near future. There continues to be uncertainty regarding lapse rates and morbidity deterioration on selective lapsation on the renewable term plans and from the ROPS rider. There is still not enough data to accurately predict how this rider will impact experience. Two insurers recently dropped the ROPS rider from their product in response to these pricing challenges.

Locked-in definitions are exposed to developments in genetic testing, improvements in technology and treatments which can have a dramatic impact on what is covered. Trend assumptions are an important part of the incidence pricing assumptions and these are also subject to medical advancements.

Most products in Canada are noncancellable. This feature results in higher capital and reserve requirements. Reinsurance tends to be used extensively to relieve the strain associated with writing the business. Coinsurance is uncommon in Canada, particularly for ROP products, and reinsurance therefore tends to be Yearly-Renewable Term (YRT) with no coverage of the rider.

MORBIDITY EXPERIENCE

The Canadian Institute of Actuaries (CIA) developed a population based incidence table in July 2012 called the 2008 CANCI table. It is used as the expected basis for industry experience studies. The table is based on population incidence rates for each of the 26 CLHIA benchmark conditions. Data was taken from the Canadian Institute for Health Information, the Institute for Clinical and Evaluation Studies, Stats Canada and Canadian Cancer Statistics. The incidence tables are gender-distinct and have been adjusted for medical definitions and claims eligibility requirements such as first-event diagnosis and the 30-day waiting period.

The Canadian Institute of Actuaries has published three morbidity studies since then. The studies exclude acceleration riders as well as group and creditor plans.

- February 2013—study period 2002-2007 based on 1,800 claims
- December 2014—study period 2003-2011 based on 5,000 claims
- October 2016—study period 2005-2014 based on 7,500 claims

Figure 4 provides a summary of the experience over the 3 study periods. Morbidity has improved overall, with the exception of amounts below $50,000 where there has been some volatility. Results by band are counterintuitive relative to what we see in life. As the amount of underwriting increases at the higher bands, we expect the experience to improve. We see the opposite in the CI experience. Our U.K. colleagues have seen similar results in their industry data where results improve in the middle bands and increase again at the higher bands. This could be attributed

to anti-selection or smaller amounts that are riders on larger life policies which have more underwriting.

As in other markets, most claims are for cancer. In Canada, 85 percent of female claims are for cancer compared to 61 percent for males. A significant portion of the remainder for males is for heart attack. The CIA study also monitors average claims and there are clearly higher claims for Parkinson's and Multiple Sclerosis. The CLHIA is reviewing the wording of these definitions as a result.

The data suggests that underwriting selection lasts about two years but wears off quickly with a 50 percent selection discount in the first year and 15 percent in the second. Looking at the select period by condition shows some interesting results—the select period for cancer is only about one year and longer for heart disease. Recall there is a 90-day moratorium on cancer claims so only ¾ of the first duration is exposed, so the select period is even shorter than one year. Data is available for stroke and other conditions, but the results are not credible enough to make any conclusions. The one conclusion we can make is that cancer is very hard to medically underwrite!

The smoker vs. nonsmoker differential in the CI data appears to be considerably less than for life where it is two to three times on average. The CI data suggests a differential of only 150 percent. If we break this down further by cancer and heart disease categories, cancer would only have a 30 percent differential compared to numbers which are similar to life insurance for heart disease. The overall differential of 150 percent appears to be thus driven by the cancer experience.

It is important to keep in mind that these latest industry results are based on only 7,500 claims in total and the credibility reduces as we dissect the data. The studies are available on the CIA website www.cia-ica.ca for subscribing members or you may contact the CIA directly.

GENETIC TESTING

Bill S-210—the Genetic Non-Discrimination Act—is a bill that has been wading through government circles in Canada for a number of years. It looks very likely that this will pass as law sometime in early 2017. The precise wording of the bill makes any genetic testing results prohibited grounds for discrimination. There is tremendous industry concern in Canada regarding the impact it will have on preferred underwriting and critical illness.

The CIA published a report in January 2016 that evaluates the impact of genetic testing on incidence rates: "Genetic Testing Model for CI: If Underwriters of Individual CI had no Access to Known Results of Genetic Tests." The report estimates the morbidity impact to be +26 percent due to anti-selection, 16 percent for males and 41 percent for females.

Canada is obviously not the first country exposed to such legislation. The Genetic Information Nondiscrimination Act of 2008 (GINA) is the counterpart in the U.S. which prohibits genetic discrimination by employers or insurance companies. However, U.S. federal non-discrimination legislation does not currently apply to Life, DI and LTC insurance. The European countries sell more short term business than in Canada so it's less of an issue.

There will many discussions over the coming weeks/months amongst insurance companies, the CLHIA and the government bodies. We are hopeful for an outcome that protects the consumers and insurers alike. ■

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