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NON-TRADITIONAL PRODUCTS FOR NON-TRADITIONAL MARKETING SYSTEMS

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- o Return of premium products
- o Long-term care
- o New product development considerations
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MR. RICHARD D. PITTS: This afternoon I would like to take a few minutes to review the progress and development of products that offer the owner a return of all or a portion of the premiums paid for their insurance.

Before we get into specifics let me offer a few definitions and explanations. When speaking today I am not referring to the immediate return of premiums such as the "30 day free look." Nor do I intend to include those products featuring an experience rated refund. I'm going to review those products, primarily used in direct response marketing, that offer to return to the insured or owner those premiums that have been paid over a specified time when appropriate qualifications have been met.

In preparing for this seminar we surveyed several companies and consulting firms that offer return of premium products. Since the list is quite long, I will only take this opportunity to thank all of you who did respond and assist us with information and material.

PRODUCTS

Let's take a look at the products that are on the market and some of their features:

Term Life

This product is generally written on a group basis and uses standard term insurance provisions. Most policies provide coverage up to a stated age such as 75. This places an issue age constraint on the policy depending on the number of years in the return feature.

The amount of coverage that is offered varies upward from $10,000 with most of us allowing a maximum issue of $100,000. As a result, the product is

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underwritten using short form applications with two or three health questions. Medical exams are rarely used.

The return of premium feature operates on a cliff basis. If insurance has been in force for a specified period, 15 years, then upon termination, all of the premiums paid to the company are returned. This return is made regardless of whether the insured terminates early or at the maximum issue age.

The product carries no cash values so there is no partial return if termination occurs prior to completing the 15th year. However, if coverage is terminated because the group is cancelled, the insured is provided continuing coverage through another policy with the same return feature.

Premiums increase as the insured ages, usually in five-year age brackets. For $10,000 in coverage, monthly premiums are about $3.00 at age 30 and rise to $30.00 at age 60.

Whole Life
Whole life coverage has seen limited use in direct response markets both with and without return of premium (ROP).

As with coverage without ROP, the return feature is provided using "birthday life" or the "last chance" age-last-birthday approach and standard marketing kits. Both individual and group policy forms are used.

The amount of coverage offered varies upward from $5,000 with the smaller amounts being used in the birthday kits. Coverage is underwritten on a short form basis.

The return feature is provided by establishing a unique scale of cash values that equate to the desired return. The return in early years is limited to a percentage of the premiums paid to the company. We use a 10% return at the end of the first year grading up to 100% after ten years. Other plans delay any return until the fifth or sixth year and then grade to the full return after 15 years. Since the cash values on this basis will frequently accumulate to more than the face amount, coverage is structured on a modified endowment basis with maturity at an age earlier than the end of the mortality table. In this event, the insured is provided a conversion privilege to continue life insurance protection.

Accident
Coverage for accidental death is provided using either group or individual policies. Standard provisions are used and insurance is provided on a guaranteed issue basis. Common carrier coverage is frequently packaged with the base benefit.

The return of premium feature is provided on a cliff basis similar to that used on term life. No return is provided prior to the 15th year. After 15 years, full return is provided upon termination of coverage.

Hospital Accident
Coverage under this plan provides for daily hospital benefits when accidents cause hospitalization and usually includes accidental death benefits for common carrier and auto/pedestrian death. Acceptance is guaranteed to all ages.

Benefits are reduced to 50% or 75% at ages 70 or 75, but generally do not terminate.

The return of premium feature under this plan is graded somewhat like that of the whole life plan. Once coverage is in force for six years, a partial 10% return is available. The return increases to 100% at the end of the 15th year. If benefits are collected under the daily hospital provision, then the return is cancelled and not restarted.

For a sample plan providing $100 daily indemnity with $20,000 all cause accidental death and $200,000 common carrier death, the premium is about $12.00 per month.

Hospital Indemnity

One of the more prevalent policies currently in the market is that providing return of premium hospital indemnity coverage. Like standard hospital income, daily benefits are provided for accident or sickness confinements. Frequently intensive care riders are added and coverage is available to all family members. Use of pre-existing exclusions allows coverage to be offered on a guaranteed acceptance basis. It usually terminates at a specified age (65) depending on the company and plan. Conversion to a nonreturn plan is usually provided at this point to maintain an affordable level of premiums.

The premium return features vary in as many ways as there are actuaries in the room. All include a limitation for benefits collected under the plan. They can vary from those as simple as cliff payment after 15 years, less benefits paid; to a scheduled return of 50% of premiums every five years with remaining premiums returned at age 65. The Continental American plans provide for return of premium after either five or ten years. Return is limited to premiums paid less benefits as long as claims do not exceed 20% of premiums. In the event claims exceed the 20% level, the current five or ten year period is closed and a new period is started.

As with standard hospital income plans, premiums can be determined on a level premium or step rated basis. For a sample plan providing $50 daily indemnity (three day elimination, two year benefit period) and a ten year return period, the monthly premium is about $18 a month at age 35 and $23 a month at age 60.

Disability Income

Disability plans were the forerunners in return of premium development. Agency operations began selling the feature many years ago and continue to do so. Not many disability income plans have been offered through the mail although recently more plans have been marketed through financial institutions, so I suspect that the return of premium plans are in the not-to-distant future.

Plans offer the full complement of disability provisions: to age 65 benefit periods, partial disability, COLA benefits, and many riders. Most plans develop surrender values beginning in the early durations (second or third year). These values start at about 10% of premiums and increase gradually until the full 100% is reached at age 65 when the policy terminates. Premium refunds are reduced by the full amount of benefits collected under these plans.

MARKETS

Much of the marketing of return of premium products has been to controlled markets. Due to the higher monthly premium, more attention must be paid to

acquiring the customer. As a result the more successful campaigns have been to those files where relationships already exist. All of the return products have been offered to captive markets, i.e. existing customers of the insurance company or its affiliates. As with most direct market campaigns, these markets will provide the better acceptance. There has been favorable response in the affinity organizations, particularly banks and savings and loans. We have continued to test in the broad market using purchased lists, but the results have not been astonishing.

REASONS FOR CONSIDERING RETURN OF PREMIUM PRODUCTS

There are several reasons why you may wish to consider the development of return of premium products.

From the marketing side, the captive and affinity markets have been receptive to the products. Offering the products provides more variety for clients (affinity groups) seeking new services for their customers.

With appropriate research and testing, return of premium products may lead you into new markets or may be used to selectively alter the age and gender distribution of your present markets.

In several of the markets, the product has improved the initial response. This is particularly true in foreign markets where response rates have improved by as much as 60%. In the states, our survey noted that the increase has not been nearly as dramatic. Most of the improvement has been in the affinity and captive markets where response rates have improved slightly. However, considering that the industry is realizing significant deterioration in response rates, any product that even maintains rates is a welcome addition to the portfolio. In the broad or created list markets, there has not been much improvement in response. Continental American and several of our competitors are continuing to test in these markets to determine if improved response can be achieved.

Generally the premium for these products will average 15% to 50% greater than standard products so higher average premiums can be achieved. This allows better management of overhead and acquisition costs as mail, kit and labor costs continue to rise.

From the experience side, the persistency of longer running return of premium programs has indicated that persistency is positively affected. Hospital income plans have sustained lapse rates five points lower than those on standard hospital plans. The same improvement has been noted on the early durations of term life return of premium programs.

Mortality and morbidity experience has been mixed. There has been some moderation in mortality and accident mortality on return of premium programs; however, the respondents have noted that the distribution of business between standard and return of premium blocks of business is such that the mortality improvement may not be attributed solely to the return feature. More improvement is expected and has been achieved on hospital income plans with return of premium. Actual claims have been lower than those expected in the early durations. It is expected that this trend can be continued throughout the life of the policy with appropriate customer service.

PRODUCT DEVELOPMENT PROBLEMS

I've grouped the challenges that face the company in developing return of premium products into three categories: pricing, regulation and administration.

In pricing, the major problem is achieving your desired return. Most of the major pricing assumptions that apply to your standard products will also apply to the return product. Adjustment is needed for persistency and claim expense as noted above. The persistency adjustment adds an interesting wrinkle to the process. We expect to obtain better persistency in the early durations, again at durations right before the return of premium and then incur a spike in lapses right after the return.

In those products that reduce the return for benefits paid another wrinkle is added. The claim expense becomes a double decrement function. In the case of the hospital income policy the number of days hospitalized becomes a significant factor in determining when restart occurs. Since hospital frequency and duration vary by age and gender this becomes a tedious calculation. In addition, any riders that attach to the policy will impact the amount and timing of return of premium. This is particularly true when child coverage is added. As a result several passes through the pricing loop are required.

When we developed our five year return of premium hospital income plan, we found that the results were particularly sensitive to the lapse assumptions. The lapses establish a corridor of acceptable returns. If higher lapses occur, then acquisition expenses are not recovered and a low return is obtained. If lower lapses occur, the premium return is greater than expected and a low return is obtained. The problem becomes more acute as the return period is shortened so most of us have stretched the period to the 10 or 15 year period in order to achieve an acceptable balance between results and premium size.

Development of policy forms is not too difficult. The return feature can be built into the form itself or attached as a rider to a standard form. Consistency of provisions is the only significant concern. In the life products, it's necessary to test the level of values and premiums to assure that the boundaries determining tax qualified life insurance are not exceeded. This is particularly true for the whole life form.

The nonforfeiture requirements need to be reviewed when developing the term life return product. Generally you'll find that unless a group form is used there will be difficulty in establishing the scale of returns without using cash values. Several jurisdictions have regulations that restrict the use of return of premium products or apply special requirements upon the return amount and timing. Most of the requirements are published regulations; however, you will find that some are internal guidelines found only upon filing.

Special attention to administration must be provided for the return of premium products. Systems must be developed to track the level and timing of premium return. Special customer service procedures need to be established to provide customer information.

Policyowner marketing programs, and by that I mean the sale of additional coverage after the original sale, are difficult to construct. Since they add to the base premium, special consideration for system modification must be allowed as well as the impact these coverages and premium would have on experience.

Special requirements are needed to administer the reserve for the return of premium. Most of the companies surveyed establish separate reserves for the feature. Calculations vary from a bulk reserve by block of business to a seriatim calculation based on policy level experience and duration. Appropriate tracking of the reserve is required to assure that an adequate but not overly sufficient level of reserves is established. As with pricing, this is a detailed calculation particularly when the level of benefits paid enters into the calculation.

In short, the pricing and administrative challenges are significant factors in the development cycle and require appropriate allocation of time and resources.

MR. ANTHONY WALTER BOSTON: There cannot be many people here who have not yet heard of Living Assurance, but in case there is the odd one or two, it is basically a life insurance policy where all or part of the face amount is paid upon the diagnosis of one of a number of specified diseases, usually heart attack, stroke, cancer, end-stage renal failure, or the undergoing of coronary bypass surgery. Largely as a result of marketing pressures, other diseases have been added by various companies, notably multiple sclerosis, paralysis/ paraplegia, Alzheimer's Disease, blindness, surgery of the aorta and major organ transplant.

However, AIDS has not been included as yet. In my view, it is not a viable addition to the list for various reasons; pricing, the potential for anti-selection and even its definition for diagnostic purposes. Nevertheless, the face amount will be paid on death resulting from AIDS.

A PTD benefit is also sometimes included, to help people who become very ill, but from a different cause. If a PTD benefit is included, the insured will get some benefit.

It is perhaps worth mentioning here that the accelerated benefit is only payable once; if a claimant has another heart attack, for example, nothing is paid at that time.

So much for what the product is. The remainder of my talk will concentrate on a few of the most important areas.

First is product design. It is interesting to compare the "basic" policy in various countries where the product has been introduced. In South Africa, where the concept originated in the early 1980s, they used conventional life insurance products. We estimate from talking to companies in South Africa that something like 70% of all policies issued incorporate a living assurance benefit of some kind.

In the U.K., although a few other companies tried it before, it only really took off when Abbey Life introduced the product in June 1987. We were closely involved in helping them develop their policy which uses a state of the art unit-linked whole life product: this is equivalent in the United States to a variable universal life.

In the United States, we helped Jackson National, who was the first company to launch the product here. They used an interest-sensitive whole life, with a 25% acceleration of the benefit on diagnosis.

You can see from the above that so far, the development has been mainly for agency force business and has used permanent policies as the basis. There is no reason why a temporary insurance of some sort should not be used and in this form, Living Assurance has a great potential for direct marketing. Indeed, we have designed just such products for clients in various countries around the world.

One thing at this stage I should mention. We do not like using the word "rider" in this context, because it implies something added on for a few cents, like waiver of premium, which is certainly not the case based on U.K. statistics.

If you try to direct market this as an optional rider to a term insurance, the cost factor alone would reduce your response rates considerably. Therefore it is necessary to revise the benefit structure accordingly and ensure that the dread disease element is fully integrated into the product.

Second is benefit coverage. There are a number of points to consider here. Obviously you must get the definitions of the specified diseases correct! The definitions we use are the subject of many hours of research and deliberation with our consultant medical officers. You need to be sure of exactly the circumstances when you would expect to pay a claim. (Please also ensure that you do not have to pay the claim twice if the policyholder suffers two heart attacks, for example). You should also be aware that the definition of some diseases (for example, stroke) may be quite different in the statistics which you might have used in your pricing model.

Third is underwriting. There is a higher possibility of anti-selection as a benefit is payable whilst the policyholder is still alive. Your underwriting philosophy must be straightforward, but it is impossible to escape the fact that underwriting is tougher than for ordinary life business. Indeed, the application form cannot be shorter than for a conventional product. In particular, we believe that more attention should be paid to the history of close relatives while they are still alive rather than just those who have died.

Next is pricing. This is a new concept and the only significant insured lives data available relate to South Africa. This cannot easily be applied to the United States as, for example, the incidence of heart disease is substantially higher than would normally be expected in U.S. There are a number of sources of information available for the general population, however, and these can be used to obtain ratios of the incidence of the specified diseases to that of mortality alone. These ratios can then be applied to the mortality basis of the company concerned.

In theory, the calculation of the premium rates depends on two factors:

1. The total incidence rate at each age of the various diseases covered, and

2. The probabilities of a life contracting such a disease at any specified age surviving for set periods of time, bearing in mind that some of the deaths will not be as a direct result of the disease. The probability of survival at any time from the incidence of the disease to the end of the normal life table is therefore required.

Assuming this information is available, a double decrement table can then be constructed with the population of lives decrementing on death and the incidence

of a named disease. The survival factors for those lives who have had a disease diagnosed can be used to determine the mortality for those lives who have not incurred the disease. From these calculations, the appropriate premium rates can be derived.

Unfortunately, there is insufficient data available to be able to derive the necessary survival factors with any degree of confidence, so we have developed an alternative method of calculating rates which I will now briefly describe.

The information required for each age is:

a) First incidence rates of each specified disease.
b) The proportion of total deaths at each age attributable to a specified disease.
c) The proportions of deaths among sufferers of the specified diseases which are attributable to the specified diseases.

Using these factors, the number of lives in the population who have already suffered a specified disease can be found from:

$$dd_{x+1} = dd_x + i_x - (l_x * q_x * pd_x/pdd_x)$$

Where: dd_x = population at exact age x who have already suffered a specified disease.

i_x = number of first claims of a specified disease during the year of age x to x+1

l_x = total lives in population at exact age x.

q_x = probability of death in the year of age x to x+1 (for the population as a whole).

pd_x = proportion of deaths arising from the specified diseases in the year of age x to x+1 for the total population (i.e., factor (b) above).

pdd_x = proportion of deaths arising from the specified diseases in the year of age x to x+1 for those lives who have already suffered a specified disease. (i.e., factor (c) above).

Once values of dd_x have been calculated, the exposed to risk can then be calculated for each age as $l_x - dd_x$. The total number of claims in the year will consist of incidences of new claims for specified diseases and deaths from causes other than from a specified disease (excluding those applicable to survivors who have suffered a specified disease). A set of cost of insurance (COI) rates can therefore be derived.

This theory assumes that 100% of the benefit is accelerated, and if a smaller percentage is accelerated, amendments need to be made.

There are two possible approaches to determine the values of factors (a), (b) and (c) above. First, it is possible to base all calculations on population data and mortality experience. The above basis can then be used to provide a ratio of Living Assurance COI rates to mortality-only COI rates. If we assume that

the same pattern would apply to insured lives, the ratios can then be applied to an appropriate mortality table.

Alternatively, it would be possible to produce a set of assumptions based purely on insured lives mortality. However, the only reasonably appropriate data currently available are cause of death statistics. With the lack of any other data, other assumptions would necessarily be subjective.

We feel at the present time that the population-based method is reasonable, but as more experience becomes available over a period of time, usable statistics based on insured lives should gradually follow.

After the "basic" COI rates have been derived, there are a number of possible adjustments which should be considered, for example, smoker/non-smoker status, female lives, potential for anti-selection (which is closely allied to the underwriting philosophy used and the existence of a waiting period, if any), geographical location and socioeconomic factors.

Finally, there is marketing. There are clear similarities between Living Assurance and cancer plans, which have been around for some time. Cancer plans have suffered adverse publicity in some markets through emphasizing the fear of the disease. The marketing of the modern Living Assurance policies has been much more positive. Some of the copy has been very effective.

In the U.K., Abbey Life's direct marketing subsidiary, Ambassador Life, has been testing a wide variety of mail kits to many different types of lists. Some campaigns have produced much higher than average premiums. There are also some that have "bombed," obviously from the lack of impact of the copy or the characteristics of the list. Ambassador also ran lead generation advertisements in the daily national newspapers, mostly of a smaller nature with curiosity generating headlines. An enquirer would be sent a specific quotation with a direct mail kit. They have also tried various incentives, such as contributions to cancer research.

To conclude, I believe that Living Assurance is the most exciting concept for direct response marketing to appear for a long time. We are developing it in various countries worldwide, including, of course, the U.S.

MR. IRWIN LOWEN: When Jay Jaffe asked me if I would like to participate in this session, he told me that the subject was "Non-Traditional Products for Non-Traditional Marketing Systems." Now I know that Jay considers himself a non-traditional actuary and that's probably one of the many reasons I think so highly of him. My problem is with the word non-traditional. I don't know what it means any more. Last year's non-traditional products and activities soon become today's norm. I think what we're really talking about is "conventional wisdom" and the things that defy "conventional wisdom." This is what being non-traditional is all about. It is the inclination and guts to defy conventional wisdom. It is a creative ability to see things most other persons can't even think of seeing. It's like seeing beyond the horizon. And, if you are a non-conventional actuary, as I believe most of you in this room are, it also means that you are a person who is driven by market needs, not by producer needs nor by conventional solutions. Admittedly, there are some people who find it somewhat easier to defy conventional wisdom because their thinking patterns have not yet been locked in by a long period of immersion in tradition.

A wonderful example of this is what happened in Poughkeepsie, New York, a little over 30 years ago. In a chance meeting between the President of the New York State Retired Teachers Association and a small local insurance broker, the Association President bemoaned the dilemma teachers faced when they retired at age 65. At the time in their life when they were most likely to face hospitalization, when they needed hospital insurance more than ever, their group school insurance policies expired, and the insurance companies, in their conventional wisdom, wouldn't issue an individual policy because they considered these individuals to be uninsurable. This insurance broker, who by the way was basically an accountant who also sold insurance, and consequently was not especially overburdened by conventional wisdom, saw a tremendous market need, and an opportunity. He had visions of tens of thousands of retired teachers scrambling to buy hospital insurance if only he could find a way to fill their needs, and then get some company to underwrite it.

As most of you have probably already figured out, this local insurance broker was Leonard Davis, and the program he brought to the New York Retired Teachers Association was the base upon which he later built AARP and Colonial Penn. By virtue of not having his creative capabilities overly traumatized by the conventional wisdom of the insurance business, he didn't realize that what he set out to do could not be done, so he found it easy to defy conventional wisdom. By defying the conventional wisdom which said that people over 65, as a group, were basically uninsurable, Leonard Davis pioneered and popularized ways to underwrite with such devices as waiting periods for pre-existing is a market need for a specific coverage, non-conventional thinking on the parts of underwriters, and actuaries, and marketers can help find a way to provide the insurance." And if the conventional channels of distribution were not properly adaptable to the product, he would find new channels. As you also know, the alternate channel of distribution he helped develop was mail order and the power of the affinity relationship. And as you also know, under Mr. Davis' stewardship, Colonial Penn continued to fly in the face of conventional wisdom and as long as they continued to do so, they continued to grow and prosper.

Take for instance the 50+ Guaranteed Life Insurance policy. Conventional wisdom said that if you wanted to sell life insurance to the older person, the policy to sell was the small face value, short form underwritten coverage, you know, the conventional burial type policies that had face values starting at $500 and running up to $2,500 in $500 increments. Colonial Penn sold one of these policies, too. Like all the other companies in the business at that time, they found themselves rejecting one third of all those who applied. In addition, they discovered that there were many older persons who did not even choose to apply, even though they were well qualified for this insurance, because of their fear of being rejected. Older persons are especially sensitive to rejection. All the other companies who sold these burial policies had similar experiences and accepted the fact that their underwriters would reject one third of all applicants since that was the conventional wisdom at that time. Colonial Penn had other ideas. We questioned the conventional wisdom of the underwriting guidelines being used. We recognized that we were probably rejecting many risks whom we could have accepted. Consequently, we maintained careful records of all individuals we rejected for this insurance and began to carefully track them over the years, and this is what we discovered. During the first two years or so, the incidence of death for those persons in the rejected group was considerably higher than for those who were accepted. This was in accordance with conventional wisdom. However, after a period of two years, the mortality experience for this rejected group began to approximate the experience of the group we had

accepted, and to whom we had issued policies. This is when we recognized that at this older age, the underwriting standards every company was using washed out much more quickly than it did at the younger ages. Consequently, we also developed tables showing the period of time required for each age group to return to normal mortality. This was the basis of deferring benefits for two years while guaranteeing to enroll everyone who applied. To compensate for the higher mortality that was still being experienced for the under 65 age group after this two year period, an adjustment was made in the benefit/premium relationship for ages 50 to 65. This produced an actuarially-sound product that was a marketing man's dream. I don't know how many of these policies have been sold since that time; but I'm sure it must be in the tens of millions.

Now let's see in what other ways conventional wisdom was defied by this actuary-marketer coordinated venture. Before we hit the marketplace, we carefully examined this new product to see what we could do to enhance its marketability. By the way, this attention to marketability was, at that time, an approach that defied conventional wisdom. Products were then being designed primarily by actuaries and underwriters. They were then given to the marketing people to sell. Unfortunately, too many companies today still run their operations in accordance with this conventional wisdom.

But, let's get back to our guaranteed issue life policy. We, at Colonial Penn, knew from our experiences with the mature market that older persons were very budget conscious. Their major criteria for making a high ticket purchase was how much they had to pay every month. If they purchased an automobile and they could afford to make monthly installment payments of $150, the length of the payment period determined the price category of the car they bought. A cheaper car was selected if they were offered one year financing. A more expensive one with three year financing. Their approach to insurance was if he could afford to budget $20 a month for life insurance, the 50-year-old person would purchase a $5,000 policy. For the same $20 a month, the 65-year-old was satisfied with a $3,000 policy. In effect, they determined first how much they could afford and then accepted the amount of insurance if bought. This did not comply with conventional wisdom which said that you sold insurance by first determining the face value and then calculating the premium according to the insured's age.

Now, let's look at the way conventional wisdom handled the two year deferred benefit period. The amount of the death benefit was broken into a number of stages. You know, $250 per unit the first year, $500 per unit during the second year, and full face value starting with the third year. However, we found that our customers considered these meager benefit amounts to be rather unattractive. It also focused too much attention on the deferred nature of the face value benefit. The solution was to refund all premiums paid, plus interest. This made it clear to the older person that he couldn't lose. He had a money-back guarantee. If he died during the first two years, his beneficiary got back an amount of money equal to, or more than, the amount that would have been paid if the premium money had been deposited in a bank. Interestingly enough, this premium refund plus interest method paid less than the amount paid by staged benefits. However, the operative word here is "perceived value." The customer felt that all your money back, plus interest, was a more attractive deal. Of course, we all know that many state insurance departments no longer permit the money back plus interest technique. But the principle of "perceived value" is an important one, one that you should always keep in mind when you develop a new product.

However, so much for the 50+ life policy. Let's move on to something which is enjoying a great deal of popularity today. Let's take a look at Mr. Average Person's problem with life insurance. Namely, what he must do to be eligible to collect benefits. Namely, he must die. Any life policy that can offer a living benefit has a leg up. Especially if this living benefit is paid at a time when the policyholder will really need some extra money.

It was some 15 years ago that I first ran into this policy, in a most unlikely place, namely South Africa. I'm talking about term life insurance that prepays a portion of the face value when the insured is hospitalized for cancer. The fear of cancer is universal. It also helps sell a lot of insurance. This policy prepaid 25% of the face value if the insured was hospitalized for cancer. This is a very valuable benefit that everyone can understand. This benefit is paid only once during the lifetime of the policy. And once it is paid, the death benefit is reduced by 25%. Thus, a $50,000 life policy would prepay the amount of $12,500 for hospitalization for cancer. And the face value is reduced to $37,500. Of course, anyone could buy this same protection, simply by buying two separate policies. That was the conventional wisdom, a term life policy plus a separate cancer hospitalization policy. By defying conventional wisdom, we combined these coverages and eliminated the duplication of marketing costs and administrative costs for two separate policies. We also ended up with a very attractive product. And the insurance company saves a great deal of money and is in a position of offering a better buy to the consumer.

That is something you should always keep in mind. What can you do that will give the consumer more value for his money? If you do this, the back end will take care of itself. And, while you're making prepayment for cancer hospitalization, why not also offer prepayment when the policyholder is hospitalized for heart attack and stroke? That's what people are really thinking about when they buy life insurance or health insurance. Those three dread diseases: cancer, heart attack and stroke.

Interestingly, this South African insurance company, in all their wisdom, fell victim to another gem of conventional wisdom. When an insured was awarded this prepayment, they also reduced subsequent premiums proportionately since the amount of life insurance was being reduced. This is nonsense. This reduced premium did nothing to add to the perceived value at the moment of purchase. The question never comes up at that time. Besides, any person who is hospitalized for cancer, or any of the dread diseases, is either uninsurable or is subject to a rated premium anyway.

Now, let's assume your company management is prepared to market this product with prepayment for all three dread diseases. You must now make a basic decision regarding your marketing strategy. Obviously, a policy covering all three dread diseases will require a much higher premium than one which covers cancer only. And since you generally get a higher percentage response with a lower premium, you may conceivably sell many more policies if you cover cancer only. This is the well recognized principle of the conquest premium. So your choice is as follows: You can go right out with a policy that has a somewhat higher premium and provide coverage for all three dread diseases, or you can provide coverage only for cancer. Have your conquest premium and possibly sell a bucketful of policies. And, then you can follow up very quickly with an upgrade opportunity. An offer to expand coverage to include heart attack and stroke hospitalizations. This strategy is known as relationship marketing. And

in a properly structured relationship marketing program, you will also quickly follow up with opportunities to upgrade the death benefit itself.

Now, one last example of defying conventional wisdom. I have been fortunate in having had the opportunity to work very closely with insurance companies all over the world. And, while I've found that all insurance companies operate in pretty much the same manner, there are distinct differences in what practitioners in each country accept as conventional wisdom. I particularly refer to what we call participating life policies and how dividend distributions from these policies are handled. In the U.K. for instance, cash value insurance is quite popular, with term insurance just starting to make large inroads, primarily in the last ten years or so. Direct response marketing has played a major role in this development. However, the British do not use the term participating policy. They prefer to call them "with-profits" policies. This is more than just semantics. Think of it. Would you prefer to own a participating policy or one suggestively labelled, a with-profits policy? The next consideration is how the U.K. companies distribute these "profits" or dividends. Conventional wisdom in the U.S. says to show the dividend as a credit on the annual premium notice. Why not? Nobody ever complains when you give them money back. However, the principal effect of this generosity is to reduce premium income to your company. Remember, when the policyholder purchased the policy he made a mental commitment to pay, and to budget for, the specified premium. If anything, as time goes on, this payment becomes less and less painful. What do the U.K. companies do? At the beginning of every year, a distribution of profits for the previous year is made to all policyholders, without regard to policy anniversary date. In effect, they sever the relationship between the dividend and premium collections. What is even more interesting is how this distribution is made. It is accompanied by a letter from the company Director and it informs each policyholder of what a wonderful year this has been, and then tells him the amount of "bonus" he is receiving. Please mind that wording. It is not a dividend. It is a bonus. And this bonus comes in the form of paid-up insurance. The result is that the insurance company picks up a massive amount of new business at the beginning of each year, and the policyholder ends up with increased coverage to make up for the erosive effects of inflation. To make this transaction a bit more palatable to the insured, this bonus coverage is often provided at a more favorable basis than the standard rate. How does the U.K. policyholder respond to all this? Well, some years back, we made an addition to this bonus notification mailing. Since nothing beats the notification of good news to help establish a favorable selling environment, when we sent out the bonus notice we included an offer for the insured to purchase even more of this same insurance -- in addition to the bonus coverage he just received. The result? More than 10% responded favorably. They purchase more insurance.

So if you consider yourself a non-traditionalist, don't permit yourself to be smothered by "conventional wisdom." Keep your eyes and minds open to market needs. Listen carefully to what the buyer needs, whether or not this is an actual perceived need or not. You might even talk to your marketing department every once in a while. In effect, think like a marketer. Then use your skills and experience to produce the product to fulfill these needs. And most of all, don't get hung up on conventional wisdom.

MR. JAY M. JAFFE: Well you have heard three different people talk about some of the thoughts that they've had on Non-Traditional Products for Non-Traditional Markets. We didn't quite cover everything in the outline but then again, there is no guarantee when you come in that you're going to get what's there. We

didn't particularly talk about any long-term care issues. I'll start off the question and answer period by telling you some of the concerns that I have developed about long-term care. The biggest one is that I find that long-term care in any market, including those that are in the non-traditional markets, is a product which may not be insurance. There is a very, very high probability that people are going to need some kind of long-term care facility and I find that it makes this a non-insurable product since the probability is so high. In other words, you have to plan for it as a certainty rather than an insurable event. You have to have a certain fund available at death if that's what you're planning for estate taxes or for retirement or whatever, to provide for another party. I think you're going to need the same thing for long-term care so that you're going to have to have so much money available at a certain point in your life to pay for those things that you need as you get older. I find it difficult to price an indemnity type product looking to the future when there are going to be many social changes, economic changes, governmental changes, etc. I'm worried that it may be a kind of actuarial timebomb. Anybody can talk about that or any other things that are on their minds. Are there any questions?

MR. MARK E. SHAW: I have several questions. Mr. Boston, in his presentation, indicated that perhaps the most important question in the living assurance policy was a family history-type question. It has been our experience in underwriting that your questions are only as good as your ability to follow-up on them, and I wondered what kind of things they had been doing to follow-up on the veracity of the answers they were getting to such questions?

MR. BOSTON: I don't really know to be perfectly honest; I'm not an underwriter. It strikes me though that if you have to ask a question about family history, it has to be detailed sufficiently so that you are covering both the history of the parents and close relatives when they are alive as well as when they are dead; if both the person's parents have had cancer, but they are both still alive and they both are over 55, then you won't necessarily reject the person at that stage, but it will certainly have a great bearing on your decision. Now as I say, I'm not an underwriter so that's not a particularly good answer.

MR. SHAW: I have had some personal experience -- not in regard to a living assurance policy, but we had a special premium and one of the factors involved was a family history-type question. Our experience was that it was very difficult to follow-up on it, so I just wondered if there was anything in particular you had found useful in that regard.

MR. PITTS: This is not directly related to the living assurance benefit, but we recently put together a long-term care plan that we were marketing through direct mail. It uses different underwriting than whole life and health coverages would use. Specifically, it was trying to address the mobility of the applicant. We used telemarketing follow-up to the application and there was quite a battle internally with the marketing area as to how that would be used because they were very concerned on a direct response mode that we would be prolonging the process, so we worked it in as a marketing tool. I think it's particularly important there that if you do use the telemarketing approach, that you have trained telephone underwriters because you are doing some voice underwriting to test the veracity of the response, and that can be particularly helpful.

MR. LOWEN: I just have a little point of information and that is that in the U.K., there is no such thing as a period of incontestability. That would help.

MR. SHAW: My second question has to do with the return of premium type of product -- one of the illustrations that Mr. Pitts gave. He indicated that on at least one of the products they had a provision for a re-start after claims reached 20% and my immediate thought was that if you had insureds who were in the 14th year of a 15 year cliff vesting and they collected 25% benefits, it seems rather inequitable to restart a 15-year period on them when if they had just collected their 25% they would be getting back 75% the next year or if they didn't turn their claims in they would get back 100%. We have had some problems with regulators on this type of provision. As a matter of fact, there was some criticism in a paper by Paul Barnhart some number of years ago on this very point -- re-start provisions where there is a threshold. What kind of reactions have you gotten from the regulators on this type of provision?

MR. PITTS: The re-start feature that we have is only contained on our hospital indemnity plan. It re-starts only at the point that the insured would no longer be eligible for any return of premium. At that point, rather than have them lapse the policy because they're paying probably 20% more than a standard plan we simply re-start, so we haven't had any adverse regulation on the re-start feature itself. The particular instance that you mentioned would give rise to some justified questions.

MR. JAFFE: I agree. There's just no answer to it except you can't do it in some places.

MR. SHAW: My third question is not really a question, it's a point of information. My company has been selling return of premium products now for 15 or 16 years and one thing we have found is that one of the advantages that you've mentioned may not be an advantage, and that has to do with persistency of return of premium products. We have found that for return of premium products with longer duration return periods, let's say 15 plus years, that persistency, especially in the early durations, is not improved by adding the return of premium benefit; in fact, it may be decreased. We found the products to be very price sensitive in that regard and this is just a warning to other companies who think that one of the reasons to get into this is to improve persistency.

MR. PITTS: Which products?

MR. SHAW: We have primarily sold specified disease, heart care-type products with this type of provision, and also some accident products.

MR. JAFFE: Return of premium products appeal to the greed of the average person. It's another way to say that they want to get their money back and they don't want to pay for their insurance, and this is a way to get their money back. Unfortunately, with the premium being more costly, as a personal observation, I don't think I want to buy that kind of coverage; if I need it, I need it. It's a tremendous marketing tool and I think where it has more applicability is where there is a low frequency rate as opposed to a high frequency claim rate. Although again people defy me and they say -- well, we sell hospital indemnity, but the premiums are quite a bit higher. Mr. Pitts, you mentioned how much higher you thought?

MR. PITTS: They can be as high as 50% higher.

MR. JAFFE: Yes, that's what I found. They're great leads but quite often what happens is after the person sees the extra premium or the premium

differential from the cheaper product that you offered them, the cadillac versus the chevrolet, they'll tend to buy the chevrolet which is the non-return of premium if you offer them both in the same marketing package. Any other comment on that from the audience or from the panel? Have you had a similar experience?

MR. SHAW: Let me just say that we sold both at the same time both -- non-return of premium and return of premium and that's where I'm getting my comparisons from; the fact that our return of premium products were more prone to lapse early on than our non-return of premium products and we attribute that mainly to the price sensitivity through the sales.

MR. JAFFE: Did you offer both in the same program?

MR. SHAW: Yes. It was optional.

MR. JAFFE: Can you give us some idea about what you felt was the percentage breakdown between the two? Was it 50/50 or 60/40?

MR. SHAW: I would say that probably more like 90% took the return of premium, 10% did not.

MR. PITTS: Were they direct response campaigns?

MR. SHAW: They were not direct response.

MR. JAFFE: Now, there may be some agent motivations behind that experience that you had which would affect how the percentages worked out.

MR. RICHARD MCLAREN KELLMAN: My question relates to the direct response marketing of living assurance and I suppose this is a question for Mr. Boston. We know that one of the key factors in a successful direct response campaign is simplicity of the product and also guaranteed acceptance of the application. Now living assurance as far as I know it is not an easy product to understand. The concept of the acceleration is not straightforward. The policy benefit wording is fairly tight. Not all cancers are included, renal failure has really to be end-stage renal failure, and also, the underwriting itself is a very tight approach to underwriting. The normal short form application form that you would want to use with the direct response campaign doesn't seem to me to be applicable here. Living assurance seems to be the type of product that an agent needs to sit with someone and explain. It doesn't seem to lend itself to being dropped into someone's mailbox and being properly understood by that person and a decision being made on that basis. My question is: how have these hurdles been met by Ambassador Life and I'm particularly interested in knowing what their response rates were like and whether there have been any difficulties with the customer accepting and understanding what he's purchasing?

MR. BOSTON: I think the answer to your question first of all depends on what list this will be aimed at and you do have to do quite a lot of research into the market itself. Obviously the product is somewhat more complicated and much more difficult for part of the population to understand, but if you market it to certain segments of the population, you can and do get much higher response rates. Perhaps these are the people who are at a higher standing shall we say, people who are interested in health; it all depends on the list you're using. I think that is the answer to the first question. And as to the response rates

from Ambassador Life, I don't honestly know them, but as I said in the presentation, some of their campaigns do very well and some bomb totally. And I suspect the characteristics of the list, the characteristics of the product and the characteristics of the product compared to the list have a lot to do with it. But as to actual figures, I don't honestly know.

MR. JAFFE: I'm going to give my gut feel for what you should do if you have an interest in a product of this type, and it's really along the lines that Mr. Lowen was using in his presentation. The idea of presenting a non-death benefit to somebody has a great deal of draw. I think you can get that across, but you may not, in a direct response situation, use the same number of benefits or the same benefits. For example, in the United States, I would for the major organ transplant; if you don't have it (the transplant), you are dead. You can live after a heart attack, you can live after cancer, but if you need a heart transplant -- that's the end right there and essentially that's got to be a fairly low-cost benefit without some of the problems including some of the underwriting problems that Mr. Boston mentioned. Then, I would think that Mr. Lowen's approach of upgrading the people could be used. And that can be done with policyholders a lot more efficiently. It makes a great deal of sense for direct response marketing.

MR. LOWEN: I'm going to give you an answer from some real experience. This was from South Africa where we sold term life with prepayment for cancer hospitalization. We sold it in two different ways and in both cases, it was within an affinity market of Barclay Card holders, which today are Visa cards, and we sold it seeking leads for agents. In other words, you combine direct response with an agent marketing set-up which is done very commonly today. The conversions by these agents were extremely high. We also sold it directly with no agents. The entire contact and sale was consummated entirely by mail and phone, and of course, the responses were much lower. If I were to take these two means of marketing per se, just on that basis, you are doing a lot better in developing leads for your agents and letting them convert it. However, that is not taking into account a very important concept and that is the lifetime value of a new policyholder. If you are doing a really good relationship marketing program, this means that within the first year that you get a new policyholder on your books, you're going to load them with options and related products and continue doing it through the first two or three years. What you have is not just a policyholder, but you have a relationship because as you know, these options and additional policies you sell through cross-marketing and upgrading are sold at a much lower marketing rate. So when you concern yourself with the lifetime value of a policyholder, you're selling directly and have full control and are not paying any additional commissions to an agent or a broker. That is the better way of selling it. It works both ways. It depends on the marketplace you have, the set-up you have, what relationships you have with your agents, how much control you have about what they sell afterwards, and if you have a relationship marketing program which operates by itself or with agents. It's a complex setup and each situation has to have its own solution.

MR. JAFFE: I just want to make an observation. I remember the old dread disease policies. I don't know how many in the room do. These were the ones that sold for $10 a year. It's interesting how we use the same term today to mean something else. That was a bad term for a long, long time. Now it's accepted in a different context. We've come full circle in a way with our terminology.

MR. BOSTON: Yes, I think with the marketing of the product, we do try and get away from those words, dread disease.

MR. JAFFE: I would think so too -- living assurance or living life. It's kind of an oxymoron at times, too, isn't it?

MR. EDWARD F. COWMAN: I would appreciate a response from any or all of the panelists with regard to what I recently found to be a rather unconventional use of conventional products to provide living benefits. Within the past couple of weeks, we received a mailing from another company. What this group was proposing to do was to obtain leads from companies or agency organizations of individuals who have been diagnosed by a doctor to be terminally ill. What they propose to do, is to have themselves appointed beneficiary and absolute assignee on these policies, in exchange for which they would pay the insured 60% of the current death benefit of the policy. While it seems to be a living benefit for the insured, something about that certainly seems non-traditional. Has anyone else heard of that and what would your reaction would be?

MR. PITTS: I got the same letter as did our company president and I got his letter shortly thereafter. It's a technique certainly, and I think you need to consider the program in its entirety. I was reading between the lines as to what the company was looking to do; it didn't really mesh with the program that we had. It gets back into asset management and asset retention for your company and for their company; it's probably less of a direct marketing tool to the insured and more of a reinsurance asset management approach for the companies involved.

MR. BRIAN R. LAU: I also received the same or a similar letter. I know if you check out the premium rates they gave there they are extraordinarily high plus the other problem is if you don't die within six months, they ask for their money back or at least you have to be recertified if you don't die within a reasonable length of time.

MR. JAFFE: You have to be recertified terminally ill?

MR. LAU: That's right.

MR. JAFFE: Well I would have some questions of public policy on this. It seems rather ghoulish and taking advantage of people, and it would greatly bother me and maybe there is a germ of an idea here, but I would hope that we could work it out without getting a third party involved in this case.

MR. LAU: That was the thing, we were just taken aghast by the whole idea and scratching our head wondering if there aren't some regulatory aspects. It would seem to go back to the days of betting the ship won't come in type of thing and it's interesting to see that the idea is apparently out floating around. I just wondered what anyone's response had been to it and what the regulators might have to say about it, if anything.

MR. JAFFE: I think if they got wind of it, they would be a little bit uneasy with it. Certainly if it affected people so that they were getting less, they are doing this on a scare basis. It just doesn't sound right to me, but I'd like to reserve comment.

MR. JOHN MICHAEL LAPELLO: I have a question on the return of premium product. It seems to me that the pricing of the product is very important; particularly the lapse assumption, and I heard somebody make a comment that at the cliff there would be a spike in the lapse rate. I'm just wondering whether anybody has any experience or has taken into consideration in their pricing any mortality deterioration because of the spikes in the lapse rate?

MR. PITTS: We don't have any experience, but none of our programs has run that long. I think it certainly is a concern because you've got a real healthy group that lasted that long, took their premium and left. You may be left with subsequent adverse mortality experience.

MR. LAPELLA: It seems to me that Mr. Shaw's products have been on the market for a fairly long time. Have you had any experience in that?

MR. SHAW: We have not experienced a spike in mortality even though we have experienced a spike in lapse rates. In our particular situation, it is because our policies were written through agents, and they see the payment of the return of premium of benefit as an opportunity to rewrite the policyholder. However, since we've been doing these primarily on cancer policies we have not seen a deterioration in the people that persist, if that answers your question.

MR. JAFFE: Yes, I would also think that even though theoretically you might have a mortality differential, it is going to be hard to measure in some of these blocks of business so maybe this is one of these cases where you just have to accept the theory when you do it in the practical world.

MR. ROY A. BERG*: Do you have any experience on the living assurance from the South African market you might share with us?

MR. BOSTON: I haven't actually, I'm sorry, but all I can tell you is that in general terms it has varied quite considerably over the years. In the early years, the experience was somewhat volatile. It ranged from 50% to 150% actual to expected. Obviously it was not helped by companies who got their definitions wrong and paid out three times the true benefit and that sort of thing. Of course, everybody learns by the experience and over more recent periods, the experience has certainly been pretty favorable. I honestly can't give you any figures, but certainly as far as I'm aware, it's well within the pricing assumptions.

MR. NEIL H. LUND: Mr. Boston, what has been your experience with the regulators as far as getting the product approved here in the U.S?

MR. BOSTON: Mixed.

MR. LUND: Can you go beyond that?

MR. BOSTON: Fairly mixed. A bit more? Very mixed. Yes, it has had a somewhat mixed history as far as the regulators are concerned. In the early days, a number of states accepted it; a number didn't. The basic problem was that a lot of regulators saw the acceleration of benefits as a health product and would only prove it as a health product. Over the months certain states have

* Mr. Berg, not a member of the Society, is Chief Actuary with American Family Life Insurance Company in Madison, Wisconsin.

changed. It is now, I understand, acceptable as a life product in something in excess of 50% of the states. I honestly can't give you an answer because it changes fairly often.

MR. JAFFE: There's also an IRS problem.

MR. BOSTON: I have heard various comments that say it is not taxable in the hands of the policyholder.

MR. JAFFE: These are opinions?

MR. BOSTON: Opinions, yes.

MR. LUND: I'd like to add one comment. At least in Maryland we've had explorations with the department there as to using an accelerated life benefit as part of a long-term care program, although pricing tends to blow you away with what you're attempting to do there. But the department has said they would consider examining such a program and would be somewhat disposed favorably towards it.

MR. BOSTON: Yes, that has been a general comment and some have accepted it and others have looked at it and then accepted it. In a few states, I do know, there is not very much chance of acceptance.

MR. LAU: To address the last question, we recently have filed a product which accelerates the benefits. We are not licensed in New York, so you probably can add New York to the list of nonapproves. There are about six states who don't approve it . There's another five who tell you over the phone that they'll never approve it, and so we've come up with 11 states out of 50 so far; there may be one or two more waiting as a surprise in the wings.

MR. BOSTON: Yes, I think that's somewhat more or less in agreement with the sort of figures I was thinking. That doesn't mean to say that 50 states are happy with it. There are however, a number of states where it hasn't actually been tested as far as I know. What their reaction would be if it was actually put forward there, I have no idea.

MR. LAU: Well, I don't know which states you're referring to but except for the few we are not licensed in, we filed everywhere. I would say that I know one state, I believe it's Massachusetts, who now disapproves it but say they're going to have a law early next year and will reconsider such products.

MR. JAFFE: I find this is remarkable, personally. Here we have a product which is really consumer oriented, and the states are not allowing us to try things. It certainly can't hurt the consumer. If they have concerns about solvency and pricing, I think those can be addressed, and perhaps next year we should have a session on non-traditional products with traditional insurance departments. We'll see what we can do.

MR. LAU: As a further comment, some of them specifically have in the law that you cannot have provisions in riders which prematurely reduce the death benefit irrespective of whether it's paid out or not. So until you can get those state legislatures to change those rulings, they'll never be approved there.

MR. JAFFE: On the other hand, the policy could be written in a different form so you paid a portion of it early and didn't reduce the death benefit and charged an additional premium. There's value to this thing, and in fact, for many people life insurance is such a large part of their estate and their financial planning in general that I think we have a valuable service to provide. I think it is a shame that the departments don't work with us and help us rather than just say no.