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Session 6PD
Dread Disease and Critical Illness Products

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Summary: Are dread disease and critical illness products the products of the future? Or, are they here today?

Ms. Christine Malevich Bellavia: About a year or so ago I had some friends over for dinner, and somehow we broached the topic of life insurance. A friend turned to me and said, "Tina, I have plenty of life insurance. I don't need any more. One thing I do want and need, however, is some type of coverage that protects me if I get a serious illness, like cancer, and I survive. That's what we're here to talk about: a product called Critical Illness (CI). This is a product that will help reduce the financial worry and strain on a person if he or she is diagnosed with a serious illness. It helps improve their chances of surviving a serious illness and also promotes independent living; if you have a serious illness, you are less dependent on the government or your family to take care of you.

Our first speaker is Dave Grimshaw. He is a marketing actuary with Swiss Re in the U.K. His degree is in economics from the University of Cambridge, and he qualified as a Fellow of the Institute of Actuaries (FIA) in 1988. He has been extensively involved in the development of CI policies in the U.K., Ireland, Israel,

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and other markets and with CI pricing, product design, and valuations since the first product launch in the U.K. in 1986. He was a coauthor of *Dread Disease Cover: An Actuarial Perspective*, which won several awards. He is the chairman of the case-mix index investigating U.K. CI experience and a well-known speaker on product design and pricing and profitability of CI products.

Mr. David L. Grimshaw: Let's start with my definition of CI insurance—the payment of a lump sum or a fixed series of lump sums on the diagnosis of one of a number of diseases or events specified under the policy. Although CI is the accepted generic term in the U.K., it's still known as a dread disease cover in other parts of the world, and as a trauma cover in Australia. Regardless of the name, to me, they all mean the same. The origins of CI policies, perhaps, lie in the cancer plans that have been sold in various countries, such as the U.S., Japan, and Israel, for a number of years. But it was in the early 1980s that today's products started to emerge in South Africa. There, life insurers were prohibited from selling any form of indemnity medical expense cover, but the existing products that were offered were inadequate to cope with the very large medical bills. CI was introduced, and most policies were sold, with the maximum sum assureds of around $30,000 U.S.—in short, to cover medical expenses.

In the late 1980s the product was imported into the U.K. and Australia even though the primary rationale for the South African product, to pay medical expenses, was largely irrelevant. Instead, CI was a marketing lead proposition, offering lifestyle protection and, subsequently, business protection too. The product has achieved some success, as we will see later, and many other markets now offer some form of cover.

In this opening session, the topics I'm going to cover are the events that are covered under CI policies: the product types, worldwide sales, claims experience (or at least what we know about it), lessons to be learned, and some success factors.

I'll start off with the events covered. In the early products in the U.K., around 1987, there were six events covered: cancer, heart attack, stroke, kidney failure, coronary artery bypass surgery (which was a bit of a strange one in the U.K., but it was brought over from South Africa), and total and permanent disability (TPD). TPD was added as a catchall, to prevent criticism of the products, in that if someone was severely disabled, they may not qualify under any of the illnesses that were listed. The definition that was used for TPD was very strict. It required that the individual be totally and permanently disabled from performing any occupation whatsoever. Subsequently, other definitions have emerged.

As new companies entered the markets, or as existing writers sought to enhance and revise their products, each endeavored to offer something new. Now the list of events in the U.K. is much more extensive (see Table 1). Worse, in a few cases, this has extended the scope of the cover. In my view, the negative aspects of this trend have outweighed the positive ones. Many of the events that have been added have been on the basis of "What can be added to lengthen the list, but that will not increase the cost?" This has lead to some stringent definitions and possibly some consumer misunderstanding. Events such as rheumatoid arthritis and diabetes mellitus have been given very strict definitions indeed. And somebody could easily be told by their doctor that they are suffering from these conditions, yet they wouldn't qualify under the policy.

TABLE 1
EVENTS COVERED: U.K. 1997

Alzheimer's disease	Heart valve surgery	Muscular dystrophy
Angioplasty	HIV needlestick	Paralysis/paraplegia
Aorta surgery	HIV blood transfusion	Parkinson's disease
Bacterial meningitis	Liver failure	Rheumatoid arthritis
Benign brain tumor	Loss of hearing	Severe burns
Blindness	Loss of limbs	Systemic lupus erthyematosus
Coma	Loss of speech	Terminal illness
Diabetes mellitus	Major head trauma	TPD
Emphysema	Motor neuron disease	Children's cover

The other effect of this trend was that the marketing and product development became solely focused on the length of the list, although, as we will see later, the core diseases constitute about 95% of all claims. Independent advisers were placed in a position where, unsure of the importance of particular events, they felt obliged to recommend the product with the longest list. Fortunately, this trend of adding new events does seem to be abating in many countries, but not because they are running out of ideas. Indeed, in some Far East countries, there is now a market agreement limiting coverage to 36 events. It's worth stressing that in the majority of products the benefit payable is a single, simple lump sum.

If CI was designed, at the forefront, for technical considerations rather than marketing ones, then we might end up with benefits suited to particular events. For example, the full sum assured will be payable on severe heart attack or cancer, whereas a reduced lump sum might be payable on angioplasty. A lump sum may be followed by a regular incremental recovery on less severe heart attacks, but perhaps you would have just a regular income increasing over time for things like multiple sclerosis (MS) or Alzheimer's. One out of two companies have followed this approach to a greater or lesser extent, but I believe they are all companies with tied distribution channels rather than operating independently.

Moving on to product types, there are two main product variations: acceleration, where the CI payment is an acceleration of part or all of the death benefit, and stand-alone, where the CI payment is independent of any other attached death benefit. Within these two categories, cover can be offered on a whole life endowment or term base. Acceleration cover is, obviously, cheaper than providing both life and CI cover independently, but it is open to the criticism that the life cover is taken away from the dependents when it is most valuable—that is, when the life assured is an impaired life.

One particular area where this criticism is not valid is loan protection, where 100% of acceleration of the death benefit means that the loan can be paid off on the earlier of death or diagnosis of critical illness. This has proved particularly successful in the U.K. and other markets where some companies are achieving 80% take-up of CI options of mortgage-related business.

The cost of this benefit to the consumer may be quite modest. In the U.K. many mortgages are repaid by means of an endowment policy that aims to repay the outstanding amount at the end of the term or on earlier death. Adding CI to such a plan, on an acceleration basis, may only add around 5% to the total cost of the policy. The bulk of the premium is for investment purposes to generate the proceeds at maturity.

Turning to stand-alone cover, this is appropriate if an individual has adequate life cover already, or perhaps I should say, if they perceive they have adequate life cover, or where there may be no need for life cover such as single people. Many of these sales in the U.K. have been mortgage related. Companies have sought stand-alone CI in respect to existing loans that may already be covered by life policies.

For many people the concept of CI appears to be simpler than disability income benefits. Benefit limitations may have to be explained. Occupation and underwriting may delay issue, and there may be a fear of insurers hiding behind policy wordings. With CI there is the simpler message—that if a disease is diagnosed the insurer will pay. One final point on stand-alone cover: Typically a survival period is included so that no CI benefit is payable if death occurs soon after diagnosis. This helps reduce costs, avoids claims disputes after death, and avoids a double payout when in reality there is no need for the second payment.

So what success has CI achieved? I'll try and explain how and why the sales have been achieved, but, first, here's an indication of some of the sales around the world (see Table 2). In some cases these are fairly rough estimates. To some extent I've defined the penetration rate simply as the number of in-force policies divided by the total population so it's not necessarily the target population for the insurance. To

some extent, these penetration figures simply reflect the length of time since CI was introduced. Spain, for example, is a relatively new market where CI has achieved some success relatively quickly, but that's not reflected yet in these figures. Also, it's a market where there is low penetration of life assurance, so I think the companies that have launched CI are very happy, so far. However, in Italy, the product has achieved very few sales to date, although it has been on sale for several years.

TABLE 2
WORLDWIDE CI SALES

	In-Force	Penetration Percentage
Australia	350,000	2%
Ireland	150,000	4
Italy	15,000	0.03
Japan	5,000,000	4
Spain	60,000	0.15
U.K.	1,500,000	3

Let's look at the U.K. in a little more detail (see Chart 1). This chart shows the number of sales by year going from about 1988 to 1996; I didn't bother including 1986 to 1987. To put that in perspective, the U.K. population is about a fifth of the U.S. The scale on this next chart is different, but the bars represent CI sales, again, going up to 500,000 on the left (see Chart 2). The line is related to the right-hand scale and shows what has happened to the total life insurance market in the U.K. during that time. As you can see, we've had it pretty rough. We have seen a declining market. Despite this, CI has prospered. For another comparison, sales of individual disability income products have declined from around 160,000 in 1991 in the U.K. to just under 130,000 in 1996.

CHART 1
THE U.K. MARKET: TOTAL CI SALES (NUMBER OF POLICIES)

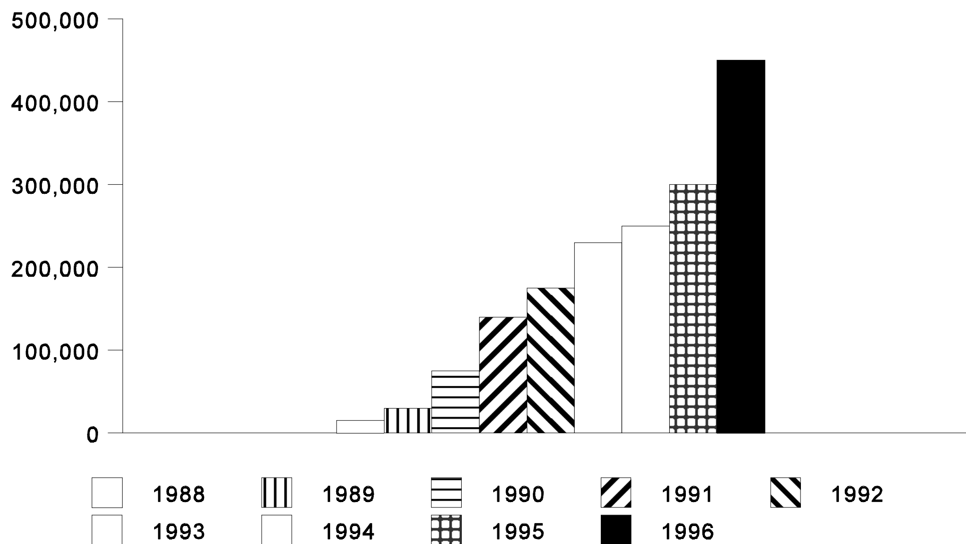
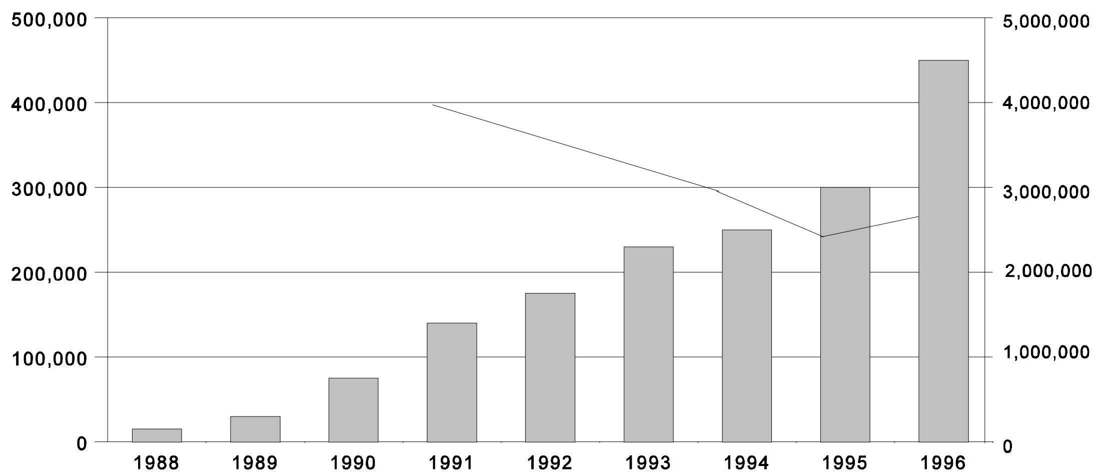


CHART 2
THE U.K. MARKET: CI SALES IN CONTEXT



Let's have a look at the breakdown of these sales, first by policy type. The vast majority of sales are acceleration. We also have stand-alone, acceleration on an endowment assurance, whole life, and term, which is a relatively new concept. Term sales grew from about 10,000 in 1995 to nearly 100,000 in 1996. Again, many of those may be mortgage related.

Who sells the business? First we have direct sales, which in the U.K. includes many of the major banks through their own sales forces. Independent brokers have had

increasing market share in recent years after a slow start. Direct business, telesales, and direct mail have yet to make much impact, but to be honest, people haven't tried them to a great extent.

Which companies sell CI? Virtually all U.K. companies offer some form of cover, but the top 10 account for around 65% of the market (see Table 3), so a significant number of companies haven't achieved very much. Many of these company names will mean relatively little to you, but I will comment on just a few of them. Standard Life at the top, AXA Equity and Law at number four, and Barclay's Life at number five are three of the insurance companies tied to major U.K. banks. Allied Dunbar is up there at number tree; Abbey Life in the middle, and Lincoln National is near the bottom. They are the pioneers of CI in the U.K. and are still achieving significant sales, primarily by direct sales forces. The remaining companies, Scottish Amicable, Standard Life, GA Life, and AXA Life, sell predominantly through independent brokers. Success has been achieved by every means generally used within the U.K.

TABLE 3
THE U.K. MARKET: SPLIT OF SALES BY COMPANY

Company	1995 New Policies
Standard Life	30,251
Scottish Amicable	29,467
Allied Dunbar	29,224
AXA Equity & Law	26,270
Barclay's Life	24,702
Abbey Life	23,382
Black Horse Life	18,484
Midland Life	17,454
Lincoln National	15,401
General Accident	14,641

Next let's look at the CI claims experience. I'm going to be drawing on various sources here: a U.K. market survey for 1991–95 that, unfortunately, isn't quite finished yet, a study of direct agent experience in Australia, a survey of the market in Ireland, and, finally, an interesting observation about India. The survey of the U.K. market experience that we're undertaking, as I say, is incomplete, but the results I do have are hot off the presses. We have asked all the U.K. companies to give us their exposure and claims information for 1991–95, so that we can measure the experience and feed it back to them. These are the areas I'm going to look at for CI experience: the overall experience, the question of acceleration against stand-alone, the split of claims by disease, and the question of whether there's been antiselection.

Going back to the U.K. market survey, as yet we've only analyzed the acceleration business on a life basis. We haven't completed an amounts survey, and we haven't yet included all the companies that sent us data. But we have over 2,300 claims, which is a fair number in relation to the U.K. market. The comparison basis I'm using for the actual over expected figures is a table called IC-94, which a group of actuaries in Ireland developed. We haven't actually gotten around to developing a standard table in the U.K. yet. It's meant to represent Irish assured lives experience.

You might ask why we are using Irish experience as a comparison basis to the U.K. Because they didn't know what to expect in Ireland, they actually used the U.K. population data as a starting point. But they did increase it for cancer because there seems to be a higher incidence of cancer in Ireland than in the U.K. It's an aggregate table. There's no differentiation between smokers and nonsmokers, and it's only an ultimate table. Nobody has yet postulated the effect of selection. Those are the kinds of results we're coming out with.

The comparison of actual claims to expected claims is for male nonsmoker, 84%, and male smoker, 115%, female nonsmoker, 73%, and female smoker, 93%. Since this covers 1991–95, there is a fair amount of short duration business included, as the market was expanding quite rapidly. Therefore, this may not be a particularly good reflection of what the ultimate experience will be like. But, overall and at the moment, we feel this looks slightly higher than we were expecting. One other interesting point to note is the smoker/nonsmoker differential, which is much narrower than we're used to seeing in the U.K., and, I think, over here for mortality business. In the U.K. we'd normally expect around a two times multiple between smoker and nonsmoker. We're not sure yet why the differential is narrower. We have to do more work in terms of analyzing the experience by cause of claim, which may give us a good clue. I think it may be a reflection of the age and the maturity of the portfolio. As we'll see in a minute, they have received many cancer claims, particularly for females. The cancer claims are primarily for breast and cervical cancer, reflecting the ages that we're selling to. Perhaps they're not affected by smoking in the way that the ultimate portfolio will be. That's the overall experience.

What about the difference between acceleration and stand-alone? We haven't yet analyzed the stand-alone from the market survey. Certainly from our own portfolio, the old M&G, and the Swiss Re portfolio in the U.K., the experience is much worse on stand-alone: 104% of expected versus 49% for acceleration in the U.K. People do seem to be selecting against companies more than they are on acceleration business. And to some extent the difference between acceleration—72% of expected—and stand-alone—98% of expected—is also reflected in the Irish experience.

Next, I'll discuss the split of claims by disease. Cancer is the biggest cause of claim for both males and females. At just over 75% , it is very high, indeed, for females, Next comes heart attack and stroke. Coronary artery surgery is slightly more common than MS, which is significantly higher for females than males. If you think back to the six events that the U.K. companies initially covered when they entered the market, the bulk of the claims so far fall under these events.

Antiselection has caused some concerns in the U.K., and certainly we were getting many female cancer claims in early durations. An apocryphal story was of a woman who took a policy out and had breast cancer diagnosed. And, yes, we did pay. Among male nonsmokers, we found 44% at duration zero, 87% at duration one, and 102% at duration two plus. This is actually steeper than we would get on mortality business, where we'd be looking at more like 75, 85, and 100 in the U.K.

This may be a reflection of the fact that we've been relatively tough on underwriting of CI in the early days. Mortgage business frequently brings its own selection. In fact, people don't tend to buy a new house if they're about to die. These figures differ slightly from the ones we've seen in other markets, but this is the biggest block of data that anybody has yet analyzed. For the Australian experience, they're measuring against population rather than against insured lives. That's the 40, 38 and 38, so basically it's pretty flat. In the Irish market, you get a fairly erratic pattern. Also, there does seem to be some selection, but not as much as in the U.K.

I said I'd conclude with a comment about India. This is probably not something you can do over here, and certainly we couldn't do it in the U.K. or other developed markets, but in 1993 the life insurance corporation of India launched a simple CI plan. They sold over 500,000 policies in a three-month period. They then withdrew the product. They waited three years and then monitored the experience. I don't know the exact results, but I do know that they have now relaunched the plan. That's one way of getting your experience, and presumably it has been acceptable.

The last couple of points I'd like to cover are lessons I think you ought to learn from the U.K., South Africa, and Australia. Then I would like to talk about some success factors. I'll start with the lessons to be learned, the tightness of the definitions. We were lucky in the U.K. because South Africa went first, and they certainly incurred a substantial number of claims that fell outside the spirit of the plan but inside the definitions they had set out.

But a few issues have emerged in the U.K., and I will give an example. There was a man with a 500,000 U.K. sterling policy, which is around U.S. $800,000. He approached five U.K. specialists seeking coronary artery bypass surgery. They all

agreed there was some arterial narrowing, but it was far too early for surgery and that wasn't the preferred route so the man went to France and had the operation done. He then claimed his 500,000 pounds. U.K. wordings generally now insist that the procedure is either carried out in the U.K. or that the surgery must be deemed necessary by a consultant cardiologist in the U.K. This is just one example, but there are others.

As I said earlier, the increasing range of covered events has proved very popular with direct sales agents who then have something new to offer their customers. But this is certainly undermining the confidence of consumers and of the independent brokers. How do they know that the product they are offering and want to recommend provides the right cover? It's difficult to overcome this without being accused of acting as a cartel. Unfortunately, the occurrence of this does seem to be lessening in most markets where CI is offered. It's something to watch out for.

It's essential that agents understand the cover they are offering. One leading U.K. company allowed its sales force to describe the TPD benefit in such a way that it appeared to be covering any other serious illness when, in fact, it was a much stricter definition, as I indicated earlier. This has led to a very high proportion of declined claims, that is around 80% of TPD claims. Not surprisingly, it has given rise to some consumer dissatisfaction. It hasn't really hit the press yet; we're hoping it doesn't.

There are many calls for a moratorium in the U.K. of perhaps three or six months at the start of the contract to counter the perceived antiselection. I think many policies in Australia and South Africa include such a clause. As the monitoring of experience now seems to demonstrate, perhaps there wasn't such a problem in the U.K., at least for acceleration business. It's certainly worth thinking about as a means of strengthening the underwriting process.

All of my comments have been about the individual business. Now for a word about group. There has been some success around the world, but primarily it's been voluntary group business that has had relatively little impact as an employee benefit. I could give you excuse after excuse why it hasn't taken off in the U.K. Basically, we haven't cracked this one. It remains to be seen whether we will.

And, finally, guarantees. In most countries, CI has been written on a long-term basis so that the cover cannot be withdrawn or the definitions mended during the lifetime of the policies. It is very difficult to assess how robust our definitions will be to the medical developments for the next 10 or 20 years. And to make matters worse, a number of countries, including the Far East and Ireland, and to an increasing extent, the U.K., are requiring guaranteed premium rates too. It seems to me that CI is too

new a product for this development to be accepted easily. At the very least, you need substantial reserves if you're going to adopt such a strategy. We don't yet have a good handle on current claims experience, let alone how this might vary over time. Even in the U.K. between about 1983, the start of our data for cancer, and the latest data, from about 1989, female cancer instances in the U.K. have increased by over 20% in just 6 years. And if they're increased at the population level, I think they'll hit the insured portfolio, too. Well, those are a few of the negative points. I'd like to finish with some positive points.

CI is an excellent product innovation for loan and mortgage cover. In the U.K. these are the big success stories. Some people have not sold CI on its own successfully, but by attaching CI to mortgages, getting the sales message through has been very successful. This may be due to the simplicity of the cover. I don't always find this easy to grasp because of the many definitions under CI policies. Nevertheless, it does seem that consumers prefer CI to disability income. They prefer the idea of a lump-sum payment that they can use as they need rather than an income that's dependent on an insurance company, which is continually testing them to make sure they still qualify for the coverage.

CI provides an excellent revisiting tool for sales forces, giving them the confidence to approach existing customers in the knowledge that they have something new and exciting to talk about. In some cases, the sales process may highlight the need for further life cover or disability income cover. But would this sales opportunity have arisen without having CI as a door opener? If you don't remember anything else I have said, I would like to stress the following point: Introducing a CI product does not itself generate CI sales. However, with training and commitment throughout an organization, a high level of sales can be achieved. The primary reason for failure in most of the U.K. and Australian companies who haven't succeeded in the CI market was that they didn't get the message through to their underwriters, claims people, and sales force.

Ms. Bellavia: I would like to move on to our next presenter, Bob Weir, who is an underwriting director with Swiss Re Life and Health and works with me in the U.S. Market Development Unit. He has his Value with Distinction and is a contributing editor for *On the Risk*, and he continues to write articles for the publication. Mr. Weir is also on the Life Underwriting Education Committee.

Mr. Robert Weir: The fact that I'm on the program talking about underwriting CI possibly highlights some of the importance that we attach to good underwriting practices for CI products. This is a product development session, so I'd like to give a plug for a high degree of involvement by your companies' chief underwriters and medical advisers. This is a fairly complex product, and the medical world is

constantly changing. Once you sell the product, if it stays in force, you're stuck with your CI definitions, no matter what happens in the medical world. Some very complex relationships exist between the conditions you're covering, the conditions that individuals have, and the risk factors surrounding these conditions. I'd like to emphasize that payment is based on diagnosis, not death.

The main thing underwriters always need to keep in mind is what disorders your company covers. You need to learn what these disorders are, what leads to them, and what the risk factors are. Also, you want to learn what does not lead to disorders and what not to be concerned about. It was interesting listening to Mr. Grimshaw talk about the 36 conditions because the more conditions you cover, the more complicated the underwriting is going to be, and the more things you have to keep in mind.

There are four areas of increased importance in underwriting CI. Any kind of previous history of one of the covered illnesses pretty much disqualifies the applicant from CI coverage. An exception to this could be an old history of cancer. I'll elaborate on this later. Family history is seen as being fairly important. One reason for this is that cancer makes up a large percentage of CI policies, not only in claims but also in the premium and the incidence rates on which pricing is started. There isn't much you can do with underwriting cancer except charge smokers more and possibly do prostate specific antigen (PSA) testing on older males. One thing you can do is look at an applicant's family history. For those with very bad family histories, their history may predispose them to have increased interest in a CI product.

The second area is the learning of risk factors. Now, these risk factors—such as smoking, hypertension, build, and cholesterol—all tend to be standard risk factors for the cardiovascular side of this product. If you think of heart attack, and, if you're covering bypass surgery, it's the same disease as heart attack. The treatment is just different. Stroke also happens to have a similar risk profile. You need to look carefully at these risk factors because they factor into many of the major coverages. I mention diabetes because it's a major risk factor for heart disease, kidney failure (which is almost always covered), and blindness. We are recommending not to accept insulin-dependent diabetics, but to accept noninsulin-dependent diabetics.

Another thing you want to look at closely is what you can term "precancels." For life insurance, we don't tend to look very closely at these conditions. However, for CI you have to look closely at what might be precancerous but may be cancerous a year from now, when the definition would be filled and you'd have a claim. Cervical intraepithelial neoplasia is a precursor of cervical cancer, and prostatic intraepithelial neoplasia is the same for prostate cancer.

Let's look at what impact history can have on some of the covered conditions, specifically heart disease. These figures are taken from the Framingham study, which showed that within 6 years of a recognized myocardial infarction (MI), 23% of the men and 31% of the women will have a recurrent MI. Nine percent of the men and 18% of the women have a higher incidence of stroke, as the risk factors are similar, and 20% will be disabled with heart failure. Within 3 years of a stroke, the recurrence rate is high at approximately 20–34%. You then have to think about kidney failure, but you would not sell a policy to someone with this. The only real exception to previous history, that I can think of, is a really old history of cancer.

I was talking about family history earlier. I have a few statistics here on breast cancer and colon cancer, which are the areas we look at closely on family history because if tends to play a fairly big role in the development of these types of cancers. The more first-degree relations you have who had these types of cancers, the higher the relative risk. With one first-degree relation, the relative risk goes up two to three times. Then, if you add another first-degree relation affected by breast cancer, you get a much higher risk: four to eight times. Also, the younger the age of the insured, the higher the relative risk will be. A 35-year-old female with 2 affected relations has a higher relative risk than a 55-year-old female with that same family history who hasn't yet developed breast cancer. There are other factors to take into consideration that also modify this, such as pre- versus postmenopausal states and uni- versus bilateral disease.

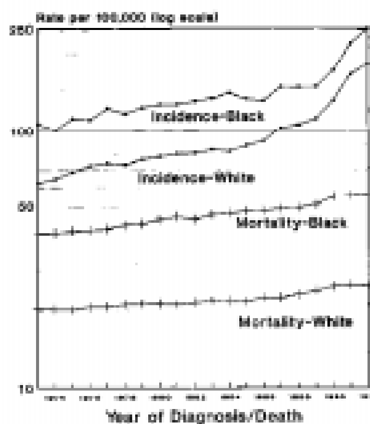
The results of a study of 4,000 females illustrates the ages of the affected relations. The relative risk skyrockets with the more relations and the lower the age—from 4.3 at age 30 to 1.7 at age 50 with just 1 sister, but from 44.2 at 30 to 17.1 at 50 with a mother and 2 sisters with breast cancer. It's similar with colon cancer, although the numbers aren't nearly as impressive: a history of cancer in first-degree relatives increases risk two times. With cardiovascular disease, people have syndromes that may lead to early cardiovascular death and early heart attacks. You really want to look closely at this; otherwise it becomes just one of the recognized risk factors. You have to do a risk factor analysis and look at the cholesterol, their build, and smoking. One statistic emphasizes how these problems can have a multiplying effect: If you smoke and have a heart attack or have a first-degree relative who's had a heart attack, your relative risk of having a heart attack is bumped up by 14 times. If heart attack occurred at a younger age and more relatives had it, the higher the relative risk.

Mr. Grimshaw: I mentioned smoking earlier, and it was interesting to see exactly how their figures came out. This is mortality, looking at the number of cigarettes smoked per day and what the relative mortality is. It's not incidence, but that's because it's really difficult to find good information that relates risk factors to

incidence so you have to believe that there's a relationship between mortality and incidence. There is a cutoff point where smoker rates may not be sufficient. We sometimes put on a small extra rating in addition to the smoker rates for a higher consumption of cigarettes. However, you have to look at how your smokers are priced to know where that would be. Mortality rates rise with higher blood pressure and higher cholesterol.

I talked about definitions and how important they are. We spend a good deal of time reviewing definitions and arguing this way and another that way. It's a very time-consuming process, but you really want to get the definitions right. You want to make sure that you're using precise medical wording because you want objective claims assessment, and you want to be consistent with your pricing. I'm going to give an example to show exactly how this works. You'll also want to look at what kinds of specialized tests you might want for diagnosis. Do you need a diagnosis to be confirmed by a specialist? Obviously, if you're covering something like MS, you'll want a neurologist; you're not going to accept the diagnosis by someone else.

Mr. Weir: We have to make an attempt to anticipate medical advances, although it may be tough. Our recommended definition for heart attack, which is commonly used, starts with a medical definition: "The death of a portion of heart muscles resulting from a blockage of one or more coronary arteries." I want to draw your



attention to what is needed for diagnosis and why we ask for three things: chest pain, electrocardiogram (EKG) changes, and elevation of heart enzymes. For chest pain, we want to see that an actual identifiable event occurred; people can go to their doctor, and the doctor will see a change in the EKG. The doctor will ask, "Have you had any chest pain recently?" and the patient may say no. This is a questionable heart attack, sometimes referred to as a silent MI. We don't really think this is a critical event worth insuring against. Then you would want EKG

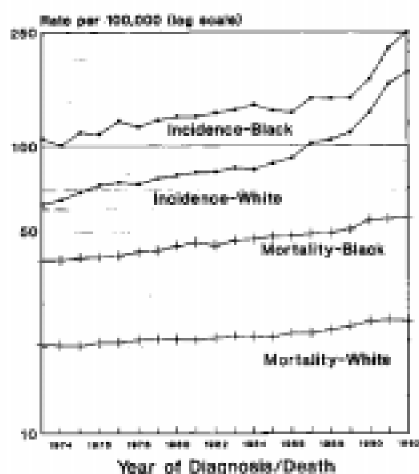
changes and elevation of cardiac enzymes to confirm that it actually was an MI and not angina. Including angina and silent MIs would increase your incidence rates, thus your rates, significantly. Incidentally, angina would be one of the conditions you probably wouldn't insure, because there's too high a risk of having an MI if you have angina.

I would like to talk about a couple of trends; The first is prostate cancer. Let me put this in the context of the definition of cancer. We started out with a medical definition again, which is in two parts: "The uncontrolled growth and spread of malignant cells and the invasion of tissue." Thus we have a number of things not covered, such as premalignant lesions, benign tumors, and polyps. They're not cancer anyway, so they wouldn't be covered, but we feel it should be stated. Carcinoma in situ is cancer, but it doesn't invade tissue, and there's no additional mortality with it. It's not a critical event, as for most skin cancers, with the exception of malignant melanoma, which does have an impact on mortality.

Outside the U.S. it's very common—in fact, almost universal—to exclude tumors in the presence of HIV. What tumors are we talking about? We're talking about Kaposi's sarcoma and non-Hodgkin's lymphoma. The incidence rates should reflect the inclusion or exclusion of tumors in the presence of HIV. If they are included, then you may want to think about doing more testing.

Our proposed definition excludes Stage A prostate cancer. This is from SEER, which is the bible of cancer statistics in the U.S. (see Chart 3). The top two figures are incidence rates. These rates are given per 100,000, and you can see that if this wasn't a log scale, but just a regular scale, these incidence rates would be skyrocketing. Mortality has gone up some what. But why are the incidence rates of prostate cancer going up so high? It has nothing to do with any epidemic of prostate cancer. It has to do with PSA testing, which is now probably the only well-accepted tumor marker, and this testing is being done all the time. This chart goes to 1992. It wasn't until 1993 that the American Cancer Society recommended routine PSA testing for all men aged 50 and up, so we'll probably see an even higher rise in the incidence of prostate cancer in 1993, 1994, and 1995.

CHART 3
U.S. MORTALITY AND SEER INCIDENCE, 1973–1992



A study was done that looked at men over the age of 50 who died of other causes, not of cancer. The men's prostates were looked at, as it's well known that many men harbor what's called indolent prostate cancer. As it turned out, about 30% of the men over age 50 who were looked at had prostate cancer that hadn't killed them. If you take this into consideration and look at the population, the study suggests that 9 million men are harboring latent prostate cancer. We're really worried about a flood of prostate claims if we include Stage A. But Stage A is just the most localized stage. When you look at the survival rate, all stages for 5-year survival are about 85%. SEER breaks it down into localized, regional, and distant. For localized, the 5-year survival rate is 98.6%, but this includes Stages A and B. Stage B is more advanced than Stage A, which I would suggest is responsible for most of that 1.4% who are not making it to the five-year mark. You can make a good case for an exclusion because of the higher incidence rates and because of the fact that the cancer isn't really life threatening at this stage.

The other trend I want to look at is covering bypass surgery and angioplasty. Basically, the disease is coronary artery disease. These are procedures, not diagnoses, and as you can see from products outside the U.S. they usually cover bypass and not angioplasty. But when you bring this into the U.S. setting, these procedures are much more common here than they are outside the U.S. When you have heart disease, there are three ways you can be treated: You can be treated with what's called medical treatment, which is basically drugs; you can be treated by bypass surgery; or you can be treated by angioplasty. What we don't want to do is have one of these where there's a benefit, as the existence of the benefit could

determine the treatment rather than strictly the medical criteria determining the treatment.

The number of bypass surgeries in the U.S., starting around 1980, was about 130,000. By 1994 the number had gone up to about 300,000. Angioplasty, however, was less than 100,000 in 1986, the first year for which I have figures. Now, however, it's more than 400,000. If you're going to cover these things, you have to factor some increase into your pricing. You also have to make this product affordable. This is why sometimes in the U.S. you'll see a limited benefit payout on bypass surgery and angioplasty so that coverage stays affordable.

Most of my talk has been comparing CI to life insurance. I realize many of you may come from health insurance companies, so bear with me. I'm just trying to compare mortality versus incidence. There's not much underwriting data at our fingertips when we're looking at one impairment to see where it will lead. You're making educated guesses and relying on the experience of your medical advisers.

I was interested to hear Mr. Grimshaw talk about antiselection and the fact that they aren't seeing it. Although Mr. Grimshaw is mostly talking about accelerated products, and even though many of the products in the U.K. are mortgage products (where you would not expect antiselection to be as big of an issue), this is good to hear. I'm gearing this presentation more to stand-alone products, and I suppose the jury is still out when it comes to antiselection and stand-alone products. We often look at the effect if you have impairment A. Is it going to lead to the covered conditions? For instance, if you have hepatitis or liver failure, what would your risk be? These are typically not covered conditions. With hepatitis you should be concerned. Major organ transplant is a condition that is usually covered. Liver transplants are becoming more common now with liver cancer, as with Mickey Mantle. That's the other thing you have to look at: What is the risk? You have to learn which hepatitis cases are more prone to progressing in these directions.

Two of the known causes of epilepsy are brain tumors and cerebral vascular disease. You want to make sure that these two causes aren't responsible for the epilepsy; if the cause is a brain tumor, you may have a claim for cancer, or, with some companies, benign brain tumors may be covered as well. With cerebral vascular disease you may not be far away from paying a claim for stroke. You need a good attending physician's statement to rule out these causes. I don't want to make it sound like we're underwriting everything on a strict base, although generally it's probably true. Some impairments are underwritten more favorably for CI than for life, such as asthma and mental nervous conditions.

As part of agent training, we would certainly like them to have an uninsurable checklist. You don't want to start developing applications on people if it's totally inappropriate, and the applications aren't going to go anywhere anyway. If you're questioning why blindness and deafness are down, it's only if these are covered conditions. If they're not, you wouldn't be as worried about them. Occupations are generally standard for CI. Some occupations may have a higher exposure to carcinogens; therefore you might worry about them more. For something like commercial diving, there might be a higher rate of stroke because of the compression. Avocations are pretty much going to be standard for CI. If you're covering for paralysis, you might want to watch out for these.

Financial underwriting is still in its infancy with this product. I keep repeating the word "antiselection" over and over. With this product you don't know what the person's needs will be. You don't know which of the covered events they will have. You don't know if they will need to modify their home because they've had a stroke and they're in a wheelchair and have to pay for it, or if they have kids who need somebody to care for them. It's difficult to plan what a person's needs will be. We know the need is there, but it can be difficult to put a number on it. There is a potential to overinsure in this situation, so we have fairly conservative recommended multiples. We're currently recommending three to five times earned income, plus an outstanding mortgage balance for personal coverage. You can sell this product in business situations, buy-sell and keyman, and in that case we'd probably like to see associated life coverage, and you would probably sell this for maybe 50–75% of the associated life cover. On the application you want to make sure those questions are going to elicit the history of conditions that may lead to the covered conditions. You want a good family history question; I've talked about that. I just mentioned the beneficiary, which is usually the insured.

Some recommended policy provisions are commonly found. All the stand-alone products have a survival period, the period of time someone must survive after the start of the critical illness. That really comes into play more in heart attack and stroke, where you could have sudden death. Well, most everyone with cancer is going to survive 30 days from diagnosis. The reason for the survival period is to distinguish CI from life insurance. CI is a living benefit. Whether the time period of 30 days is the right one could probably be debated, but this is the time period generally used in Canada and overseas. This may not look like an attractive policy provision because you don't get any benefit, but you can make it more attractive by having a small death benefit payable or a return of premium provision if the insured dies during this period.

I talked about some of the antiselection seen with cancers, especially with breast cancer and maybe with melanomas as well. Those comments are based in part on

conversations with some people in Australia, where this is a more common problem. In Canada, they've had an initial waiting period of 90 days for cancer. It appears that we really can't do this in the States. You might be able to use a 30-day survival period, which would probably be across the board. Some states may not even allow this. The survival period pays on the first occurrence of one of the insured risks and then terminates unless, of course, you're paying a reduced amount for some conditions like bypass surgery, in which case you may pay a reduced amount after that. The last thing I want to mention is that you should reserve the right to confirm a diagnosis by your own physician. What happens if an insured has a heart attack while he or she traveling outside the country and you don't really know whether he or she had it or not? You want to have the right to confirm the diagnosis.

Ms. Bellavia: The next presenter is Paivi Liitela. She has worked in the Canadian insurance industry for about 12 years, the last 10 years with Met Life in Canada. Although her initial work experience was in the corporate and pensions area, she has worked in individual life for almost the past six years. She is now the director of Life Product Development and Pricing. Ms. Liitela is also an FSA and a Fellow of the Canadian Institute of Actuaries.

Paivi A. Liitela: I'm going to try to give you a broad overview of the products that are currently being sold within the Canadian marketplace. We'll be looking at the history of CI within the Canadian marketplace: What products are being sold, what these products look like, and who is buying these products. I thought I would also touch briefly upon market conduct issues, as well as give you my own personal list of success factors. I might mention that I'm going to be speaking more from the point of view of a distributor of the product. Within our company we have four distribution channels. The primary one is a dedicated career agency force, so many of my comments may reflect this.

I've only worked with CI since 1994, and I was surprised to learn that this product has actually been available in Canada since 1988. At that time, four companies were selling CI in Canada. If you were to measure these companies in terms of their individual life sales in the Canadian marketplace, they were not large companies. From 1989 to 1992 four more companies started selling CI. If we look at what these early products look like, they were generally accelerated-type policies. Mr. Grimshaw distinguished between accelerated and stand-alone. These are generally accelerated benefits and they covered four primary illnesses. Benefits were normally capped at a quarter of a million dollars. Benefit periods ran up to age 75 and sometimes to age 100. Premiums were fully guaranteed. This is unique if you consider that this was a fairly new product. For cancer, we've heard about this

exclusionary period for cancer claims because of antiselection. Normally these early products did not have a cancer exclusion period.

I couldn't find anything in terms of sales numbers for these early products. What I do know is that the products that are being sold don't look like the products that were being sold back in the late 1980s in Canada. Perhaps low sales were one of the factors. I think a couple of other things happened in the early 1990s that really led to a change in what CI looks like in Canada. First, I think what we were seeing in the Canadian life insurance industry was that sales of individual life insurance had really slowed. We were not seeing the same attractive and healthy rates of increase in life sales as we'd seen back in the 1970s and 1980s. Insurers were looking for ways to turn this trend around and to improve things. One of the things they were looking at was distribution capacity. We've had a number of mergers and acquisitions within the Canadian marketplace. But, at the same time, they were also looking at new products they could introduce that would be unique and new within the Canadian marketplace.

Second, companies recognized that not all needs were being met. We have government-provided health plans in Canada, and employers provide medical insurance benefits. Certainly the basic medical costs were covered for anyone who contracted one of these illnesses. But people really had to rely on their own personal savings if they were to make the lifestyle changes that were necessary to adapt to life after one of these illnesses, whether they were paralyzed and had to construct wheelchair ramps in their home or they had to hire someone to do their housekeeping and take care of their children. There are many needs for which they had to rely on their personal savings.

Finally, we also had aggressive marketing by the reinsurers within the Canadian life insurance industry. They were coming to our doors saying, "Look, we have sales numbers for you. We can show you what the product has done in the U.K. We'll tell you the mistakes we've made and what we've done to change those trends." They also told us that they had to have one valuable thing that we needed, and that was data. With data, we would have the basis to start pricing these products ourselves. So, we see that things started to turn around, and a new generation of products came onto the marketplace, sold by different companies.

We had some early entrants into CI in 1994–95, but by 1996 we had a flood of new companies come into the marketplace (see Table 4). This list is by no means complete, but what is notable is that it shows that some of the larger companies on the Canadian individual life side are now selling CI, which we had not seen previously. Also, one of the companies that came out with this product in early

1997 was somewhat unique in that its product was being sold only to women. I think, again, that people are looking for that marketing edge.

Of course, in marketing we have a number of sales pitches: "Why wouldn't you buy a product that would provide you with complete piece of mind?" or "A little extra for a lot of piece of mind when you can't afford to be critically ill" are the lines that are being used to promote the product not only among consumers but also among the field force. These are great lines that are obviously trying to appeal to a need that we have recognized is out there.

TABLE 4
RECENT ENTRANTS INTO THE CANADIAN CI MARKET

1994:
Commercial Union: Life Cheque
Prudential Assurance (Mutual): Stand-Alone
1995:
Laurier Life (Desjardins): Lifestream
1996:
Desjardins: Harmony (Quiétude)
Toronto Mutual: Health Security Plan
Empire Life: Vital Link
MetLife: MetAssist
Canada Life: Life Advance
Seaboard Life: Medical Crisis Recovery Plan
Sun Life: Sun Assist
ITT Hartford: Rebound
Mutual Life

It's still very early for the CI product, and we're only starting to get preliminary sales data in Canada. The first published numbers came from a market scan conducted by the Life Insurance Marketing and Research Association in January 1997, in which five companies participated. I should point out that these five companies did not all sell CI for all of 1996. Many of these companies had sold CI for only a couple of months within 1996, so this is by no means a complete year's worth of data. A grand total of 1,722 policies were sold in Canada, according to that market scan. I will remind you that Canada is one-tenth the size of the U.S. You can do some simple actuarial extrapolation and say that, if these sales were made in the U.S. marketplace, they might equal about 17,000 policies. If we look at premiums, this would be about $1.6 million, which is Canadian dollars. The total face amount would be just under $186 million, the average size policy would be just under $108,000, and our average premium would be about $949.

You're probably thinking to yourself, "Is this product successful, and are these good results?" Well, I have to remind you, as Mr. Grimshaw showed you earlier, that the product was very slow to begin even within the U.K. The biggest factor that you will face is that the consumer doesn't know this product. We see many promising signs, though. Within Canada, we've seen over the last month some very impressive articles in some of the major newspapers talking about CI. Both the *Globe and Mail* and *The Financial Post*, two daily papers that are widely read among the business community, carried three articles talking about CI. I'll mention the *Globe and Mail* article, which was accompanied by a photo of an attractive young woman. The poor woman did not have a CI policy and had recently contracted cancer. Under the photo was a caption that read, "If this product had been available ten years ago, I could have really used it when I found out I had cancer." I think anyone who read that caption, even if they didn't have a real interest in the report on business, probably picked up and read something about CI in Canada. We see many promising signs that this product is going to be promoted more. We're also seeing articles within various professional journals; I know that the *Accountants Monthly Newsletter* had a little piece about using CI within your financial planning.

We've heard some discussion of the basics of CI, and I'll quickly go over them again. Once there is a CI diagnosis, the benefit is normally paid if the individual is alive 30 days afterwards. In Canada we see the use of an exclusionary period for cancer; 60 or 90 days are common periods. Only one CI benefit is paid per policy. This may seem obvious to you and me, but this was one of the most commonly asked questions when we rolled out the product to our representatives "If you have a heart attack and three months later you have cancer, do you get the benefit twice?" No, you only get it once.

In terms of the illnesses, we saw that there was very extensive coverage in the U.K. Coverage is somewhat more compact in Canada. We have a standard list of illnesses that are covered. I think the only other illness I have seen included on a couple of policies is coma. Based on discussions that I've had with other people within the industry, the only change I anticipate on that list in the near future is the addition of Alzheimer's.

Mr. Weir alluded to a return of premium benefit, and we commonly see a return of premium benefit available with our CI policies. Our representatives had asked, "What if the person has a heart attack and dies 10 days later? Do they get the CI benefit?" No, they don't. They did not satisfy the 30-day survival period. What we would do, however, is refund the premiums that they paid for the coverage, and normally this is how the benefit is provided. It's an automatic feature of most policies. And, again, you only pay one or the other. If the policy is kept in force

and the person either dies or gets one of the critical illnesses, they can't get both benefits while the policy is in force. It's either the return of premium or the CI benefit that is paid.

A couple of companies are providing a somewhat different form of return of premium benefit. This is really a rider for which they pay an additional premium, and it is packaged in one of two ways. Either of these basically provide that, if the CI benefit is not paid and the policy is maintained in force, at certain periods in the future the company will refund some portion of the premiums that have been paid for the CI coverage. This form of return on premium is not as common, but it is out there. In terms of how this form impacts on premium, I looked at one of the company's rate cards, and generally it caused the premium to rise by about 25% in total, so this form does carry a price tag.

The product is fairly simple in terms of structure. We see it most often as a renewable term 10 product. We have seen some companies with a level term to 65, 75, and even to 85. Issue age always starts at 18 and may go as high as 60, and in some cases 65. Benefits are provided up to the age of 75 or 85.

Premiums are fully guaranteed. Again, this may be something that is completely inappropriate in the U.S. marketplace, but the Canadian marketplace is driven by guarantees. There is not a single company out there that is selling the product without fully guaranteed premiums. Premiums, as with regular term products, are often banded at different face amount levels. For renewal premiums we see select, alternate, and attained age scales of renewal premium rates.

Benefits can start anywhere, from as low as $25,000 or $50,000 and with maximums as high as $1 million. Sometimes the maximum is $500,000. Some companies will announce to their representatives that the maximum is $500,000, but they'll reserve the right to do special quotes up to $1 million.

In terms of premiums, is CI expensive? Some of our agents thought so. I've given a comparison using my company's premiums for a $100,000 and a $250,000 policy for male, nonsmoker, ages 30, 40, and 50 (see Table 5). As you can see, the CI premium is anywhere from two to three times that for a typical term product. I'd like to point out that there is one small bias within this comparison. For the term 10 premium, at the $100,000 level, the renewals are not guaranteed, whereas the CI renewal premiums are guaranteed. As well, for the $250,000 level all premiums are guaranteed for both the initial and renewal terms. One could say CI is certainly more expensive than a term product, but this is the point where you remind agents that you are more likely to have a heart attack and not die than you are to die of a heart attack.

TABLE 5
LIFE VERSUS CI: PREMIUM COMPARISON

	Age 30	Age 40	Age 50
CI $100,000	$360	$540	$1080
Term Ten	172	246	493
CI $250,000	825	1275	2625
Term Ten	290	430	940

CI is being sold with a number of additional coverages. We're seeing many of the riders that you'd see with a normal life policy, such as a waiver premium, accidental death and dismemberment, and various term riders. The one rider that is not offered by our company is charitable donations. One company does have this built-in charitable donation feature. Some of the marketing people might come to you really upset that they didn't think of it first. The charitable donation feature provides that, if a CI benefit is paid under the policy, the company will make an additional charitable donation to an associated charity. For example, if someone were to have a heart attack and the benefit was paid, a donation would also be made to the Heart and Stroke Foundation. It is an attractive marketing feature that doesn't carry a high price tag. I think it is unique.

Who is buying the product? At this point, we are seeing primarily people who are self-employed. Representatives are some of the biggest purchasers of the product. As soon as they understand the product, they buy their own policy. Then they go to their family and expand from there. The ratio of male to female is basically 60 to 40. The average issue age has been about 41 years, which I believe is slightly higher than what the U.K. statistics have shown.

Now I'd like to make some miscellaneous observations that are based on our company data, so they are by no means representative of the industry. We have seen that the places of our CI product are comparable to our places for the life side. We do have a higher percentage of applications that are not completed. If we go back to the comments made about underwriting, the agents are probably thinking in terms of life expectancy. They're not recognizing yet certain factors that may not have an impact on life expectancy, but that will have an impact in terms of underwriting CI. An educational issue is still important, and it's one that you'll face particularly when you first go out and sell the product. I don't know if things have changed. I think there has been a total of two claims in Canada; it's still early, though. The first claim was for a heart attack, which was approved and paid, and I can't recall what the second claim was for.

Next I'll make a few brief comments about market conduct. My first comment is in regard to training. CI is a product that is very new, and you are going to have to

spend much more time training your representatives. You're not going to be able to get away with sending out a field release such as, "Here's a new product that we have. Here's the illustration software. Have fun!" Also, you will have to focus on what the product looks like, what critical illnesses are covered, and the definitions themselves. You will have to spend some time talking about underwriting because the underwriting process is extremely important. Changes will likely be required in your applications to sell this product. And you'll probably want to talk about how to sell the product and what pictures you'll use when you're trying to get someone to consider purchasing a CI product. We found that when we rolled the products out to our agents, we were often using timelines on charts to point out different waiting and exclusionary periods. Also, some of the definitions themselves contain time periods within them. For example, paralysis may require that the person be paralyzed for 180 days. But then, afterwards, there is still a 30-day waiting period that the insured needs to survive before the benefit is paid. There are many things to keep in mind, and we found significant value in using timelines. Training is a key issue.

The other point I want to make is that we're seeing legislation being passed in Canada that requires plain language policies. Many companies are moving toward plain language policies simply because they want to identify themselves as exemplary customer service providers. If you ever wanted to consider plain language policies, this might be the time to do it. CI is a complex product, and if you can put it down in terms that a layman can understand, I think it's a wonderful exercise. There are many firms out there that will offer their services and help you with this type of exercise. We have been using plain language policies within our company for a couple of years. From a marketing point of view you might think this is outrageous, but we were really concerned about the number of exclusions that were provided for some of the illnesses. Within our list of definitions in the policies, we would have a boldface subheading—"Exclusion"—that pointed out the exclusions for each illness. We really wanted to bring it to everyone's attention that you have to review this subheading carefully. We wanted you as well to grasp it visually when you first go through the policy. We haven't had a single complaint from anyone in our field force or from any clients about this, so we think it was a good move.

When we launched CI within our company we decided to do a short customer survey. We phoned customers who had bought the product, but excluded representatives and their immediate family from this exercise. We asked the purchasers a simple series of questions such as, "Were you satisfied with the description of the illnesses given to you by your representative? Did the representative explain that there were a number of exclusions?" Sometimes people did ask us questions. I have to confess that, in a couple of situations, we had to

have our underwriters call the physician back with a more technical description of some of the definitions. This did happen, but people were more than happy to give their comments. We felt it was well worth the cost of carrying out the entire exercise.

Finally, my comments on factors for success. This has been addressed by both Mr. Weir and Mr. Grimshaw. You need to have a coordinated head office effort when you go out and launch CI. CI is so new. If only for the sake of saving time, you should get everyone involved from day one. Otherwise, you're going to spend three hours talking about something with your lawyers, and then you're going to spend another three hours with the customer service staff; the time adds up. If you can get everyone together right up front to air out the product description, point out the exclusions, and so on, you're going to save yourself a great deal of time.

Once you've gathered your head office team together and you've designed your product, the next big step in the whole CI campaign is to sell the product to your representatives. They have no special insights and very often have not heard of CI before. CI is very complex, and, again, I'll refer back to our training sessions. We were telling the agents about the CI benefits and the return of premium. We threw in 30-day survival periods. We threw in a 90-day exclusionary period. We talked about these technical definitions, and then we told them, in the same breath, that there were exclusions for things like Duke Stage A colon cancer and carcinoma in situ. At this point, a couple agents were shaking their heads and saying, "I don't know if I really want to get involved with this." You have to show them what this product can offer and go through a mountain of material. However, once the agents catch on to the product and realize how powerful it is, they'll have no problem going out the door and selling CI to their families and their other customers.

To make sure your agents can sell, make sure you give them the proper tools. This may include illustrations or software; the uninsurable impairment checklist is essential. Have them do some of the preliminary screening. Again, agents think in terms of life expectancy, and they're not going to recognize who is not a good risk for CI. You may want to send them sample policies before you even start selling the product, so that they can review the terms and become comfortable with them. You would want to share with them any documents that explain the product or the exclusions in layman's terms. Also, you would want to share any facts that you can get that list the probabilities of contracting various illnesses.

Next, you have to continue to reinforce that CI is not life insurance. I have one example. We had a situation in which a representative had gone to see a client and written an application for both life coverage and CI at the same time. The

application goes through underwriting. The life application comes back, and the applicant is rated nonsmoker. The CI application comes back, and the applicant is rated substandard. Actuaries and underwriters will understand this; it's a completely different process for both CI and life, and this could happen. But the first time it did happen, a couple of our representatives were not happy. You have to reinforce, from day one, that CI cannot be looked at as a life product. We're looking at a different decrement with CI, and you have to continue to reinforce this all the way through your training and throughout the lifetime of the product.

Last, but not least, look at whom you've sold life policies to in the past because after your agents buy a policy on their own life, these are the people they're going to go see next.

Mr. James E. Carter: Based on your discussions, CI has been described as a life product sold by life agents. I wonder if you have any experience selling it as a health product by health agents? This question is posed to whomever wants to answer it.

Ms. Liitela: I can't comment about what happens within the Canadian marketplace. I don't really know. A number of agents are selling it. Where I work, CI is considered a life sale. We don't sell much health coverage. Perhaps Mr. Grimshaw has some experience on the U.K. type?

Mr. Grimshaw: Yes, certainly as far as the markets I know, which are the U.K., Australia, and South Africa. But we don't have the same distinction there. A few companies who write private medical insurance business also sell CI. But, by and large, it's primarily the life insurers who are selling the business.

Ms. Bellavia: I have some information from a few of the Canadian disability insurance (DI) agents selling the product. One of their comments is that they find CI to be an easier sale than DI.

Mr. Yiji S. Starr: I wanted to ask a question from a policyholder's perspective. Can the panelists compare the uses of DI medical insurance and CI products to satisfy the different needs of the policyholders?

Mr. Grimshaw: Yes, one of the things Ms. Bellavia asked me to cover was the uses of native CI products. As far as I know, nobody in the U.K., at least, has actually conducted this sort of survey. I could give you only the result of a sample of one, which was a claimant I actually knew. I think you have to accept that the CI generally sold is not a needs-driven product; it's not the perfect vehicle for income replacement or for medical expense cover. We have better products to meet these

specific needs. CI provides a benefit that you use flexibly according to your needs at the time. One can find a good deal of merit in considering a product that attempts to structure the benefits more to the actual event or illness that a person suffers. But then this does lose out in terms of simplicity; you're no longer saying we will pay *X* dollars on any one of these events.

Mr. Weir: Sometimes the needs can't be seen that far ahead of time, like reimbursement of expenses, but if somebody has a heart attack, and they go back to work and they're used to working 80 hours, and now they can only work 40 hours and their income level has dropped—I've even heard of a case where a person was let go in this situation, and that can certainly help there. Some things aren't covered, and you can get into long rehabilitation situations. This maybe gives you a choice of alternative care that you wouldn't have otherwise or maybe topping-up benefits.

Ms. Bellavia: A claim study was done by M&G in the U.K. that analyzed all the DI claims to see if there was any overlap with CI. I think that they found that, out of all the DI claims, only about 20% would have qualified for CI. They were typically, I guess, the cancer benefits.

Mr. Grimshaw: I think it was slightly higher than 20%. But certainly in the U.K., DI claims can be anywhere up to 70% in respect to muscular skeletal and mental nervous disorders. There is relatively little overlap. These claims are causing many problems in terms of claims management on DI business in the U.K.

Mr. Henry B. Ramsey III: I have a question about the initial waiting period. If a state regulator prohibits the use of an initial waiting period and says it has to be zero, would coverage have to start immediately? What changes in policy design do you recommend to control antiselection?

Ms. Bellavia: We would advise limiting the payout on cancer for the first N days (N days being significantly longer than 30 days), rather than having a 30-day waiting period that wouldn't pay anything. You could pay out a nominal amount or certain percentage of the face amount if a person is diagnosed with cancer during this time frame. It's really cancer that we're worried about with antiselection. For example, with breast cancer, potential for self-diagnosis is present. If you feel a lump, you can go out and buy a CI policy, and then get it confirmed. We're just trying to protect ourselves from those instances where someone can actually self-underwrite.

Mr. Grimshaw: In the U.K. we don't have a waiting period, and our primary savings to date have been because most people do not have a sufficient awareness of CI. Their first reaction if they find a lump is not, "I'll go and take out a CI policy."

I mentioned the claims analysis that we are undertaking at the moment. One of the things we'll be looking at closely is the shape of experience during the early period. The view from the U.K. is that we can provide for it.