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Critical Illness Insurance—Bringing Life to the Death Insurance Industry

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Summary: Critical illness insurance is a runaway success in many English-speaking countries around the world and has now arrived in North America, where it is gaining wide acceptance in Canada. Critical illness insurance solves many problems that existing insurance solutions do not, so the potential market is huge and untapped. Yet the product is slow to gain acceptance in the U.S. market. Could critical illness insurance be the broad-based protection product that will inject some life into the death insurance industry?

In this session, the panelists briefly review the various critical illness insurance plan types, look at the unique problems they solve relative to traditional insurance solutions, and show their success in other insurance markets. The Canadian market experience is examined and lessons for the U.S. market are drawn from this experience. The current challenges and opportunities of the U.S. market are explored, and, lastly, the role of the reinsurer as a partner is examined.

Mr. Emile Elefteriads: Your panel hopes to inspire each of you to add a little bit of critical illness insurance (CII) into your death insurance portfolios. We'll provide you with an overview of the product as well as share the experience of two companies who have launched such products.

I'll be your moderator, as well as a panelist. I am director of CII for Swiss Re Life & Health's Canadian and Caribbean individual division. I've been heavily involved with CII since 1994 and have worked with more than 20 companies throughout the Western hemisphere in countries such as El Salvador, Columbia, Argentina,

Trinidad, Barbados, Jamaica, and Canada to help them develop critical illness products for their markets.

Lynne Patterson is vice president and chief financial officer for Manulife Financial's Reinsurance Division. Previous to that she worked at Swiss Re Life & Health in the U.S. individual division, where she had broad marketing and management responsibility for a region of the U.S. While there she helped several clients develop critical illness products.

Scott Luchesi is president of Garden State Life. Scott joined the company in 1982 as vice president and actuary, became chief marketing officer, and then finally elevated to the role of president. Garden State, an innovative company, was the first to offer fully underwritten life insurance via direct media, and I think they were the first to do the same for CII as well. Scott has been instrumental in the development of their current critical illness product.

Rino D'Onofrio is a consulting actuary with PricewaterhouseCoopers in Toronto where he assists his clients with pricing and product development, among other things. Previous to that, he was with Canada Life in Toronto, where he had financial management responsibilities for the company's universal life and term-to-100 products. What makes Rino a valuable member of this panel was his role in the development of Canada Life's critical illness products, which are considered to be the golden standard in Canada.

I'll be providing you with a high level overview of the product while leaving the details to Lynne, Scott, and Rino.

Specifically, I'll cover what critical illness is from a simplified perspective. I'll talk about the need for CII and what problems it solves for people, the markets and who's buying CII, how it's doing from a sales perspective in North America and in other parts of the world, and, finally, why I think companies should be marketing and developing this product for their markets.

What is CII? CII is an insurance product that provides for a lump sum benefit on the diagnosis of a contractually specified insured condition. After the benefit is paid, the contract terminates. The premium and benefit structure resembles life insurance.

For example, imagine a term to age 65 CII policy with a face amount of $200,000 that provides for a benefit for the insured conditions cancer, heart attack, and stroke. Then, if the insured is diagnosed before the age of 65 with one of these conditions

(as defined in the policy), the policy will pay the benefit of $200,000 and then terminate.

The beauty is that the insured uses the money any way he or she wants to solve his or her own problems. There is no requirement of impending death, hospitalization, or disability. The insured either suffered the event as defined or did not.

How do the insured conditions form the heart of a critical illness policy? Here is a typical definition for the insured condition heart attack: The diagnosis of a death of a portion of a heart muscle, resulting from the blockage of one or more coronary arteries. The diagnosis must be based on both new electrocardiogram changes, which support the diagnosis of a heart attack, and elevations of cardiac enzymes. The definition is clear, has objective criteria, and is phrased in medically acceptable terminology. Of course, silent infarctions wouldn't and shouldn't be covered under this definition.

Other insured conditions that are typically found in CII polices are life-threatening cancer, stroke, paralysis, kidney failure, coronary artery bypass surgery, major organ transplant, multiple sclerosis, blindness, and deafness. These are what I consider to be the core ten insured conditions and each of these must be rigorously defined in the policy.

Other, but less common insured conditions that may be found in the North American products are Alzheimer's Disease, Parkinson's, and total and permanent disability.

In other parts of the world, such as the Far East, the U.K., and Australia, a CII policy may have more than 25 impairments! Needless to say, some of these impairments are extremely rare or are simply a partitioning of a broad-based condition such as total and permanent disability

What happened in these markets was that one company was trying to outdo the other for alleged competitive advantage, and brokers were demanding more impairments for the sake of offering the most comprehensive product to their clients. Companies added these impairments with little to no impact on premium rates. That tells you something about the value that these additional impairments added.

What is the need for CII? CII is a needed product because it solves many of the economic insecurity problems associated with suffering and surviving a critical illness that traditional insurance solutions do not.

Recall that economic insecurity primarily consists of loss of income, additional expenses, insufficient income, and uncertainty of income. Thus, in order to appreciate the role of CII, imagine being diagnosed with cancer or multiple sclerosis; suffering a heart attack or a stroke, or becoming paralyzed. What sorts of problems will you encounter? How does traditional insurance meet these problems? How does CII solve them?

First, CII isn't a good solution for the loss of partial or total income, temporarily or permanently. The best solution is disability income insurance, since it meets the need with Swiss-like precision.

Second is the problem of reduced or uncertain income because of unwillingness to work at previous levels of output. I'm not talking inability, just unwillingness: "I've had a heart attack, and God has spoken to me and commanded me to 'take it easy.' CII can help me here because it provides funds to allow me to finance a transition to a less stressful occupation or something I might actually enjoy doing!"

Third is the problem of additional expenses associated with acute medical care. The perfect solution already exists—medical insurance. CII is not the answer to medical insurance problems; in fact the stand-alone version of CII, which Lynne will tell you more about, requires you to survive 30 days from the date of diagnosis, so it is a terrible solution. You may not live to receive the benefits! Sadly, some producers in Canada try to promote the product this way, as a cheap form of out-of-country medical insurance.

Fourth is the problem of additional expenses associated with drugs and therapies. Here medical insurance is the best solution, of course, but where CII plays a role is for drugs and therapies that may not be covered by medical insurance such as experimental cancer treatments. CII gives you the cash, therefore giving you choices.

Fifth is the problem of additional expenses associated with modifying your home and lifestyle so that you can cope with your condition. Disability Insurance (DI), medical insurance, and life insurance don't help here. CII helps because it gives you funds that you can use to modify your home and car to make life a little bit better for you.

Sixth is the problem of additional expenses associated with paying for things that you could have done before, but now can't—things like taking care of the kids or the home. All these things cost money. Critical illness gives you cash.

Seventh is the problem of obtaining the best health care in a timely basis. In Canada, for example, the healthcare system is starting to deteriorate as evidenced by long waiting lists for bypass surgery and cancer treatment. If you are diagnosed with cancer, perhaps you want to receive treatment at MD Anderson rather than be treated in a Canadian hospital. That's what the rich do. CII gives you cash and that's the only difference between the rich and the rest of us. Cash gives you choices.

Eighth is the problems of fear, anxiety, and insecurity related to a shortened life expectancy, and what the impact of that condition is on your family. When you suffer one of these illnesses, you're in a period of physical and financial distress. While money doesn't buy you happiness, having that cash will relieve you of some of the stresses associated with suffering one of those illnesses. Your creditors may sympathize, but they still want the loan repaid pronto. Imagine the stress reduction if your CII policy provided a lump sum benefit to clear your mortgage and business debts. Your recovery may even be faster!

Last is the problem of opportunity loss. After suffering and surviving a critical illness, you're often not the same person as you were before, even if you completely "recover" or you're not disabled. You may lose your edge and be more reluctant to give 100% effort in everything you do. Consequently, your career or business may not take you as far as you planned. CII can give you the cash to help compensate you for some of these opportunity losses. No other insurance product can claim that benefit.

CII fills in the gaps. Regardless of how much life, DI, long-term care, or medical insurance you have, there will be gaps in coverage. CII provides you with cash in a time of physical and financial distress to close some of those gaps. It gives you flexibility and choice and lets you solve your own problems in your own way. That's what CII insurance is all about.

Let's look at some of the markets for CII.

1. The creditor market. Imagine a creditor product that pays off your mortgage (or loan) when you die or when you are diagnosed with a critical illness. The marketing messages are fantastic : "If you suffered a heart attack, would you rather lose your home or your mortgage?" Such a product exists, and it has been a huge success in the U.K. where more than 70% of the new CII policies sold are for this specific application.

2. The family market. Many of the applications for this market were touched on in the previous section. CII is about making life easier after you have suffered and

survived a critical illness. You can pay off your mortgage and your debts, modify your home, use money to take care of your children, home care, and all that good stuff. CII gives you the choice and flexibility to solve your problems.

3. A tough market to crack for the life insurance industry is the singles market. It's clear why single people don't have an interest in life insurance. However, CII provides for independence, choices, and freedom. These are important values to singles. Thus, CII has the potential of tapping into this market more so than other insurance products; in particular, the female market because women tend to be more conscious of health-related issues than men. A properly designed and marketed product could allow you to tap into the women's market successfully.

4. The self-employed. This consists of small business owners, contract workers, and professionals. These people have debts, and CII could provide them with that critical cash to keep their creditors at bay and their businesses afloat.

5. The small business market. Here CII can be used in buy-and-sell agreement amongst partners. If one of the partners suffers a critical illness, it is agreed in advance that their ownership is bought out. It can be used in key person situations as well.

6. The big business market. CII could be used for key person applications or as an executive perk. Executives are under stress and at risk of contracting one of the typical critical illnesses. The lump sum could be used to retire the executive since chances are that even if they return to work, their productivity may not quite be the same.

7. The group market. CII can be used in traditional group applications. For industries that are not eligible for LTD, CII may be an attractive alternative. In addition, CII can be offered as an optional coverage in cafeteria plans and could be more attractive to a young workforce than life insurance. Another application is the work-site market.

Who's buying? The typical U.K. and Canadian purchaser is male, employed, and belongs to the middle to upper classes. We find that the CII purchaser is a bit older, more affluent, and more females buy this product as a percentage compared to the life insurance purchaser.

In Canada, sales are very low with about 5,000 new policies being sold in 1997. However, they're moving in the right direction, and this year we'll probably see a doubling of that.

What is interesting is that the Canadian growth pattern has been very similar to the Australian growth pattern. In Australia, there was explosive growth over the years 1992 to 1994. Sales have now leveled off, but, what's interesting is that the creditor market still hasn't been tapped into, so in my opinion, there is still considerable upside potential in Australia.

The star market and the one we know the most about is the U.K. CII has had a stellar performance with sales going in only one direction. Last year sales were up 30%, which was on top of a 55% increase the year before. The amazing thing is that the penetration is still very low in the U.K. and public awareness of the product is still relatively low.

Why should a company consider marketing CII? There are several reasons in my opinion: (1) to replace declining life sales; (2) it's a global sales success, and if you're global you're going to be in this market, like it or not; (3) companies have the potential to earn a higher return on capital; (4) it enables companies to become positioned for a living benefits future. (The underwriting is different from life insurance underwriting since the risks and risk factors are different; the claim adjudication process is also different because you're dealing with live people at claim time and need to confirm that the insured did suffer a critical illness as defined in the policy. Living benefit insurance deals with the future. CII will help your sales force and your technical staff make that transition); and (5) what's most important is CII will help solve many of the financial insecurity problems that plague our customers when they are diagnosed with a critical illness.

Ms. H. Lynne Patterson: CII is certainly not a new concept here in the U.S. Many of you may remember a study that was done by the ACLI back in 1994. At that time there were almost 30 companies offering some form of critical illness coverage, then called dread disease coverage. Many of those companies would probably agree that there wasn't a huge success with those products from a sales perspective, and they probably attributed it to a lack of promotion of the concept, particularly to their agents and brokers.

In the last couple of years we've seen growing interest in critical illness in the U.S. from a variety of sources. Certainly, from an individual sales perspective for many of the reasons Emile outlined earlier, there are potential markets. But, there's even more interest in the employee benefits marketplace—both in terms of adding the product to the core benefit package offered by the employer and making the product available on a voluntary basis through work-site marketing.

Plan Types

There some key decisions to be made when designing a critical illness product. The first one is whether to offer the product on a stand-alone basis or on an accelerated basis.

Stand-alone critical illness product pays a lump sum for only the diagnosis of one of the covered conditions and not on death. It's very straightforward and easy for both the salesperson and the purchaser of the product to understand.

Acceleration, on the other hand, while it does provide a lump sum, is made through an advancement of the death benefit in the associated life insurance policy. The benefit can be as little as 25% of the death benefit advance or as much as 100%. The balance of the death benefit, if any, would be paid out on death.

With the acceleration approach, you need to ensure that you're not interfering with an overall financial plan that led to the purchase of the life insurance coverage in the first place since the death benefit is reduced or eliminated after payment of the CII benefit. Certainly in the mortgage or creditor market that's exactly the type of approach you'd want to use.

One of the key distinctions between stand-alone and acceleration is how it's viewed from a regulatory perspective. A stand-alone product is typically filed as a health insurance product, while an acceleration product is part of the overall life insurance filing. Scott will talk further on this.

Scope of Coverage

Another big decision is the conditions you want to cover in the product. A study of the general public was done in the U.K. in 1994, and what was revealed was that 85% of the perceived need for coverage could in fact be met by just having the following 4 core diseases covered: heart attack, stroke, cancer, and renal failure.

However, in the U.K., some CII plans have more than 30 impairments, often offered at little additional cost. In some cases the impairments added are silly, but it does depend on the market that you're targeting. There may well be benefits in adding a couple of surgical procedures like bypass or angioplasty. Targeting older ages, such as Alzheimer's or Parkinson's disease, may be a good idea as well.

Benefit Structure

The richest product design is to provide a level benefit for the lifetime of the insured, but that can get expensive. One of the obvious ways to reduce the premium is to have benefits terminate at a certain attained age, perhaps age 65 or

70. If lifetime benefits are offered, then it may be a good idea to cut the benefit in half after a certain age, such as 65 or 70. This will keep premiums lower.

Another way to keep the premiums down is to offer limited benefits for some of the less life-threatening conditions, like angioplasty or bypass surgery, where only 10% or 25% of the lump sum would be paid on these events.

Premium Structure

The premium structure could be level premiums throughout the coverage period or increasing premiums with a low go-in price. In Canada, the most popular form is a ten-year renewable premium structure, with premiums increasing after each 10-year period, but level within each ten-year period. In the U.S., ART is the common structure after the initial period for term life insurance. This could prove to be a popular format for CII as well.

The key difference between the Canadian marketplace and the U.S. marketplace is that in Canada the premiums tend to be fully guaranteed and noncancellable. In Canada, most producers insist on fully guaranteed products and aren't sympathetic to the fact that an experience base may be lacking as was evident with the term-to-100 product. Of course, one needs to be very careful when pricing products that have guaranteed premiums.

Policy Provisions

Stand-alone CII is a living benefit coverage. The way to emphasize this is by having a provision that requires a period of time that the insured must survive following diagnosis of a covered condition, typically 30 days. This distinguishes it from life insurance that focuses on death. The financial problems of death are best solved by death insurance.

The survival period helps to keep premiums down because it eliminates the need to pay claims on the heart attacks and strokes that result in very early death. It certainly makes claim adjudication easier because the insured must survive for 30 days before being eligible for a claim.

Another provision common to both stand-alone and acceleration is the waiting period, which can be defined as the period of time from issue or reinstatement where no claim would be honored for a diagnosis or symptoms leading to the diagnosis of a covered condition, typically cancer. This provision is a result of concern over the possibility that the insured could potentially antiselect against the company at the time of issue through self-diagnosis of a covered insured condition. The easiest example to think of is breast cancer in women. The scenario is that a woman may detect a lump in her breast, strongly suspect it is breast cancer, and

then take out a CII policy before visiting her physician. Once the diagnosis is confirmed by the physician, she makes a claim and there is very little the insurer can do to defend itself against that blatant antiselection without a provision like the waiting period.

The concern is real. Studies were done in other parts of the world showing higher than expected incidence of early claims, particularly cancer claims. The response in the Canadian marketplace has been to put in a 90-day waiting period on cancer. For stand-alone products in the U.S., state insurance departments typically will not approve products with more than a 30-day waiting period. However, some additional protection can be obtained through having a reduced benefit on cancer for the first three-to-six months.

Other Design Elements

For stand-alone CII plans, typically you'll see a nominal death benefit provided in addition to the critical illness benefit. This way, if death occurs before a CII benefit is paid, at least a benefit is paid to the beneficiary even though the insured may not have survived the survival period. The death benefit is usually in the neighborhood of 10–25% of the face amount.

Another way of providing something for death is by returning the premiums. It's a nice marketing feature.

Something that is often talked about, but I haven't seen anyone do it in practice, is to build in a provision to allow conversion at retirement to an LTC product. This makes sense since the needs of the insured change as they get older.

In Australia and South Africa, something that's available on acceleration products is the buy-back option. This permits the insured to "buy back" without evidence of insurability; the life insurance coverage lost after a CII benefit is paid. The price for this privilege can get quite expensive, and you have to wonder if it wouldn't be better to just buy stand-alone critical illness and life insurance separately in the first place.

Pricing

In North America, there is no insured experience upon which to develop incidence rates for this product. The incidence rates could be developed from experience from other parts of the world, but you do have to question how credible some of that experience is since this product is still young even globally. In addition, it may not be appropriate to use experience from other parts of the world for North American pricing since frequency rates can differ significantly. For example, bypass surgery is common in the U.S., but not so common in the U.K. The best approach

is to use incidence rates that are developed from population and medical studies of the general population and then apply a number of adjustments to these rates to arrive at an expected insured rate. A key adjustment is for the underwriting process. In addition, you should trend the rates into the future by taking into account what you expect the future to hold in terms of the behavior of the underlying disease and also in terms of advances in medical technology that may lead to early detection and increased survival of diseases.

Table 1 is intended to give you a sense of the expected claim costs by insured condition. We show results for a male nonsmoker 30 and 50. You can see the mix of the present value of expected claims is quite different between the two.

TABLE 1
EXPECTED CLAIMS COSTS

	Male NS Issue Age 30	**Male NS Issue Age 50**
Cancer	40%	47%
Angio	4	4
CABG	3	5
MOT	5	1
Stroke	6	12
Renal Failure	6	4
Heart Attack	32	26
Paraplegia	4	1

The purpose of Table 2 is to demonstrate the death benefit savings in the pricing of an acceleration product compared to a stand-alone product. Savings result because for certain insured conditions a payment under the CII portion of the policy will mean no payment under the death insurance portion of the policy. Cancer is a good example of that. The savings are typically reflected in the critical illness component of the acceleration plan. What the numbers show is a comparison of the cost of a pure stand-alone CII versus the critical illness component of the acceleration plan less the death benefit savings. Of course, to realize these savings, the life insurance needs to be purchased. Of course, the combined package is going to be more expensive than stand-alone critical illness coverage on its own.

TABLE 2
SAVINGS IN EXPECTED CLAIMS COSTS
ACCELERATION VERSUS STAND-ALONE

Issue Age	**10 Year**	**Lifetime Reducing @ 65**	**Level for Life**
30	6%	24%	28%
50	18	30	33

Table 3 shows a comparison of premium differences between life insurance and stand-alone CII. For example, for a male nonsmoker, lifetime coverage, with $100,000 of face amount reducing to $50,000 at age 65, the stand-alone critical illness coverage is about 60% more expensive at issue age 30 and about 80% more expensive at issue age 50 relative to a life insurance plan with the same premium and benefit structure.

TABLE 3
PREMIUM COMPARISON

Issue Age	Death Benefit Only	Stand-Alone CII
30	390	620
40	540	930
50	770	1385

Risk Management

Finally, I'd like to share with you a few general comments on overall risk management. This is a product where you want all disciplines to be at the table from day one—such as marketing, legal, systems, underwriting, claims, and actuarial. You don't want your marketing people concluding on design before you actually start to play with numbers and then tell your underwriters about it just before the first case comes in. You want everyone to be involved in understanding the type of risk that you're taking on, since it is so different from the life insurance risk.

It's important to also involve your medical directors and lawyers when deciding and then defining which insured conditions you want covered.

On the topic of underwriting, there's obviously a whole spectrum of underwriting that could occur with this type of product. At one end you have the fully underwritten product characterized by obtaining full medical evidence, a long application, and a full attending physician statement. At the other end, you have the guaranteed issue product in the employee benefits market, where you control your risk by offering small amounts and demanding minimum participation rates. One of the most important aspects of the CII product is that the underwriting processes need to look at different and additional risk factors relative to life insurance. Family history is a good example of that. In life insurance the event underwritten is death. With CII, it is diagnosis of a condition, which may precede death by several years, if death results from that condition at all.

The adjudication of claims is more complex than in life insurance simply because the beneficiary is the insured who is still living. The diagnosis of a covered condition is more involved than a diagnosis of death. However, it's certainly not as complex as disability claims adjudication.

Mr. Scott Luchesi: I think Lynne and Emile gave an excellent general overview of critical illness and it's major components. What I hope to do is to give you a practical U.S. case study by going over some of the components of our particular product and sharing with you some of the issues that we faced in designing and filing the product, getting it approved, and ultimately marketing it. Garden State Life is a direct response marketing life company, so my comments are made within this frame of reference.

Product Overview

Our product may be characterized as a stand-alone critical illness plan and can be summarized as follows:

- Plan type: Stand-alone critical illness
- Survival period: 30 days from the date of diagnosis
- Waiting period: 30 days from the date of issue and the date of reinstatement
- Insured conditions: invasive cancer (10% if diagnosed within the first 180 days), heart attack, stroke, renal failure, paralysis, bypass surgery (25% of face amount), angioplasty (25% of face amount), blindness, deafness, death (10% of face amount)
- Benefit Period: To age 100
- Benefit Pattern: Level, but reduces to 50% at age 70 and beyond
- Amounts: $25,000–250,000
- Issue Ages: 18–64
- Expiry: On payment of any benefit, except for bypass and angioplasty where the face amount reduces for the partial payment
- Premiums: Sex and smoker distinct, payable to age 100
- Premium pattern: Level to 100 or level for 10 years then ART (premiums do not reduce after age 70)
- Substandard: To table 4

We chose to go stand-alone versus acceleration because we did not want to force our customers to buy life insurance when they didn't need it in order to get something that they did.

We include a death benefit in our product, which provides that if the insured dies during the waiting period, the survival period, or from some disease that's not listed, we will pay 10% of the face amount to the beneficiary. The reason we did that is that we were concerned that without it someone could buy the policy, pay premiums on it for several years, have a heart attack, and die after 15 days, and no one would get anything out of the policy. We really did not want critical illness to become the next vanishing premium problem when it came to market conduct.

A few comments on some of the more nonstandard insured conditions. Angioplasty and bypass surgery are covered. They are attractive benefits, but they also occur at a high frequency. In order to keep prices reasonable, we limit the benefit to 25% of the face amount. As with all the other conditions, you can only collect once on each of those benefits, but in this case the face amount goes down by the amount that you've collected and the policy continues until there is a full claim.

We included paralysis because we were concerned that without it this product could be perceived as only having appeal to the older ages. With paralysis, some younger people would get interested in the product because there's some recognition that almost anyone can get into an automobile accident.

In order to deal with the anticipated antiselection that Lynne referenced, particularly with respect to cancer, we have the 30-day waiting period. However, that still is not enough for the cancer, so in the event of a cancer diagnosis after the waiting period, but before 180 days are up, the cancer benefit is only a 10% benefit. We cut our issue age off at 64, since we wanted to avoid overlaps with Medicare. The general thinking is that the benefits will be nontaxable to the recipient if premiums are paid with after-tax dollars. I will tell you, just like I tell our customers, that as far as I'm aware, there's no private letter ruling where the IRS has taken a position on the issue. Thus, we essentially tell our customers to consult their tax advisor before buying the product.

Our product is primarily nonmedical at the lower issue age amounts. We do not have guaranteed issue at all, and at the larger amounts, we will do medical exams.

Regulatory Environment. A tremendous amount of time was spent filing and trying to get this product approved in the various states. Thus far we filed in 46 states, have approval in 26, have 5 pending, and we've been disapproved in 15.

Our expectation for this particular product design is that about 30 states will approve this product. In order to get more states to approve, we'll have to make some changes.

One of the issues that we have is that for individual health insurance the NAIC model defines eight different types of health insurance, and critical illness doesn't fit in any of them.

In almost every state, the commissioner has discretionary authority to approve new and innovative products. Hopefully, you may have had more success than we had in trying to get the commissioner to actually exercise that authority.

I should point out that many of the regulatory road blocks could be overcome by making changes to the plan design. However, there are some states that simply do not like this product at all.

There are at least two states that we're aware of where you don't even need to bother wasting your filing fees because critical illness is just prohibited outright in the regulations and sometimes by department policy because they just don't like lump sum specified disease type of coverage. Death benefits are not always allowed in conjunction with health insurance policies in several states. This isn't a big issue since we have two versions for our product—one with and one without a death benefit.

Interestingly, there are two states that will allow you to have a death benefit but you have to file the product twice—once with their health division and once with their life division—and you have to satisfy all the requirements of both.

In general, there were three features of the plan that generated objections. If these were addressed, we probably would have the product approved in 40 states instead of 26.

The waiting period is one plan design feature that generated some filing problems. In those states that approve such a provision, they limit it to only 30 days. However, there are numerous states that will not allow a waiting period at all, and the rationale for that is that you cannot charge a premium for a period in which you do not provide coverage. We came across one state that would permit a "waiting period" of 30 days, but to them, a waiting period is exactly what it sounds like—you can wait until the end of 30 days to pay the claim! We found that didn't reduce premiums very much!

The next issue was the survival period. In our minds the survival period is fundamental to this type of coverage. It's what separates CII from life insurance. This is a living benefit, not a death benefit.

Their reasoning was that the survival period results in an unjustifiable delay in paying claims, and is an extension of the waiting period. Some insurance departments do not like having benefit triggers that are keyed to a compound event (diagnosed with a heart attack and having to survive 30 days from the date of diagnosis). To them the point was, if you get the disease, you pay the benefit.

As some of you may have already guessed, the reduced initial benefit for cancer is our methodology of trying to find at least a reasonably cost-effective way of dealing with that gatekeeper type of protection against the antiselection since 30 days is

really too short. Some states saw this as an extension of the waiting period, and would therefore not permit it.

In virtually every state, you must offer the stand-alone critical illness as a supplement to basic health insurance. There are several states where you even have to get an affirmative response on your application from the insured that they actually have basic health insurance, or you are prohibited from selling it.

Information on family history is an extremely important element in terms of risk evaluation. There are at least two states that do not allow you to ask family history questions, and there are several more that preclude you from asking family history questions under the guise of genetic testing.

One of the other issues is that virtually all the critical illnesses products that I've seen exclude certain types of cancers: noninvasive skin cancers, stage A prostate cancer, and a few others. There are some states that say you cannot distinguish by category of disease. You have to wonder what need is being met if you have to pay someone a benefit of $250,000 just because they had a cancerous mole removed. In order to avoid these expectations, we advertise our cancer coverage as life-threatening cancer.

Marketing

Who did we think was going to buy this? We focused primarily on people who do not have a caregiver at home, or two income families where if one person got a critical illness and lost their income and the other person had to stay home to help them, it would be conceivable that two incomes would be lost. The small business market that was mentioned earlier was also part of our target.

Single people are an example of people who do not have caregivers at home. Older people who have accumulated assets for retirement and would like to have some assurance that those assets would not be drawn down are another market.

We did a considerable amount of secondary research on the product. We spoke to actuaries in countries where they have experience with the products, such as the U.K., South Africa, and Australia. We also did some test marketing.

We did primary research in the form of focus groups. We found associated with the unaided responses that there was a very poor understanding of the potential of contracting and surviving these diseases. Another problem was people felt they were totally covered by the health and DI they had at work. With the aided response, I went into the room and discussed with the people some of the misconceptions and then left the room. This time, much of the skepticism was

gone. I'm not saying that everybody had their checkbook out, but they were at least significantly more willing to consider the viability of the product.

The conclusion, which is great for those of you who work for agency companies, is so far from our perspective: Critical illness is in fact a product that must be sold and not bought.

We had some challenges in our direct marketing going from the qualitative market research, the focus groups, to the quantitative market research, which is essentially putting the product out there and seeing what happens. In our tests, we wanted to let the market tell us who the market was going to be for this product. We also did some television and radio advertising.

Our test results were interesting. We obtained a 50/50 gender split, which is in contrast to our typical life insurance gender split of 75 male/25 female. Emile mentioned earlier that there was good potential for this product in the female market. On those lists where we could identify the gender of the people we mailed to, we found that our response rates were double for females than what they were for males, so there's some support for that.

Most of our applications were in the, and I hate to use the term, low-income groups. They're lower than we had anticipated, but 57% were under $25,000, and a full 80% were under $50,000.

Initially, we were concerned about not being attractive to the younger age group. This turned out not to be a problem since almost half of the applicants were under age 40.

Consistent with the lower income amount was the lower face amounts. Approximately 50% opted for the minimum, $50,000. Ominously, of the ones who opted for the larger face amounts, the vast majority of them were uninsurable.

We did expect that we were going to get into a nontraditional section of the marketplace, and that's what we got. More than 55% of the respondents belonged to the unmarried group (single, widowed, divorced, and separated).

The occupations were relatively consistent with income. They were typically blue collar workers or in an unskilled labor market.

The market we found, which was not the one we were looking for, were those people in those occupations who did not have basic health insurance and, because of their income levels, were very unlikely to be able to afford any kind of

comprehensive health insurance. So, this particular product served a very important, better-than-nothing kind of purpose for these people. They could get affordable coverage and receive a significant amount of money to help pay for the medical expenses should they be struck with one of those illnesses. The real problem with that is in a state like California, where you can't sell it to them. You are prohibited from selling critical illness to people who don't have basic health insurance.

It's clear from our market research that the major part of the sales effort is going to be overcoming the misunderstanding and the lack of knowledge about the breadth of coverage. People need to understand that disability, life, and basic health do not cover all of their health insurance needs.

The one-size-fits-all model is not going to work in this market either. You're going to have to really do some needs analysis on your potential customers and focus your sales or marketing message to the particular marketing segments. We're boiling down the marketing to the most fundamental emotions of need, greed, fear, and control.

Everyone is familiar with need, greed, and fear. The industry has been emphasizing them for years. Control however, is going to be a growing and much more important issue. Emile referred to it before; if you live in Canada and were struck with cancer, you might want to go to MD Anderson because you want the best care you possibly can get. We're getting more and more of that in this country with managed care. We don't say you can't have it, but we do say, if you do get it, you're going to pay a larger deductible with higher co-payments, and so forth, for going out-of-network.

Garden State Life is committed to going forward with this product. We think that with enough time and enough public education, this will be the product of the future.

Mr. Rino D'Onofrio: I will share with you some of the events and experiences as well as the challenges Canada Life faced when we launched CII to the Canadian marketplace.

The Canada Life Insurance Company was one of the first major insurance carriers to launch critical illness products in mid 1996. We were able to design the product, price it, introduce it to our administrative systems, and put together a slick marketing package, all within six months. What follows are some of the trials and tribulations of that experience.

This was the first time that Canada Life had introduced such a novel form of insurance to Canada, so the marketing of it was quite unlike that of any other type of insurance we then offered.

Why offer such a product? In order to answer that question, we first need to look at the current reality of the Canadian marketplace. Emile touched on this also.

The market for life and DI is extremely competitive, with many companies vying for a larger share of a relatively flat market. The number of new individual life sales has actually been declining for several years. At Canada Life we've been competing harder and harder to just maintain a relatively stable share of this market.

The company was and continues to be committed to not only maintaining but growing its market share. In order to do so, we began to examine all the factors that impact the sale, distribution, and administration of our products—the so-called value chain, which includes product development, distribution, underwriting, new business issue, product administration, and claims. We realized that although our life and DI products have some unique features, there was often very little differentiation between our products and those of our competitors.

This coupled with the flat overall market figures indicated to us that we needed to explore ways to set our existing product portfolio apart from our competitors and hopefully open up some new markets along the way.

While Canada Life is committed to modifying and enhancing its existing portfolio products, we also undertook an analysis of product offerings in other countries. One product jumped out at us, and that was CII. It had taken off like a rocket ever since it was introduced in South Africa in the mid 1980s, and the experience was similar in countries like the U.K., Australia, and Japan.

Furthermore, Canada Life had significant positive experience with the product through its European operations.

A few phone calls to our colleagues in the U.K. confirmed all the hype. They were convinced of the need for this type of insurance, and the sales there were phenomenal.

There were a few other positives as well. Offering such a new form of insurance to the Canadian marketplace would give the company the opportunity to be seen as a leader and innovator since Canada Life had a reputation as a stoic, conservative company. This was a reputation the company wanted to shed and by offering CII, it gave us the chance to do so.

In addition, Canada Life had a significant amount of experience with the product in the U.K. Our colleagues across the pond were very knowledgeable and were willing to offer us guidance as we designed and launched this product.

Finally, there were only a few players already in the market, and we felt that being one of the first majors to offer the coverage would give us a competitive advantage.

Canada Life's product development team consisted of representatives from the marketing, actuarial, underwriting, and claims departments, along with some key field associates.

We had a meeting where we introduced the idea to the team, and there were both positive and negative reactions, particularly from our marketing and underwriting areas. The negative reactions centered around either the need for this type of insurance or the potential cannibalization of the existing DI product line.

Our marketing director disliked the product. In fact, after listening to our presentation, he summed our product up as "DI for morons, and morons are not part of our target market."

A few of our underwriters were of the same opinion, although they didn't express themselves quite as eloquently!

Thankfully, there were other people in the marketing and underwriting departments; in particular, our key field associates who were really taken by the product. They saw the need and knew of situations where they could sell it and were excited by the chance to market and distribute a new type of insurance. Eventually, we were able to win over the marketing director and the underwriters.

Canada Life made a strong commitment to this product initiative because we soon realized that such an initiative could not succeed if it was done in half measures. The key reason for this is that the product is distinctive, particularly in the way it's positioned, in the mind of the consumer and the way it's sold by brokers.

From a consumer perspective, we thought that CII would be a tough sell because consumers might have a tendency to deny their need for it. We thought that it couldn't be sold the way life insurance is sold, so it required a different sales approach on the part of the broker.

Success would require major marketing and field training support and altering perceptions. We handpicked the underwriters, claim adjudicators, and marketing

staff needed to support this product, providing us with a top-notch team that had a healthy mix of both confidence and skepticism about the concept.

We looked at the rates our competitors charged for CII coverage in Canada, as well as the rates charged in the U.K. They were extremely high when compared to life insurance with the same structure. We decided to take what we call the Chevy/Cadillac approach and offer one with a relatively low initial premium (a renewable term-to-age-75 product with rates that increase every 10 years) and the other with level premiums and lifetime coverage. The term 10 was made convertible to the lifetime product without evidence of insurability.

We then had to decide whether the product would be noncancellable or guaranteed renewable. Our research in the Canadian marketplace indicated that there was a demand for noncancellable, and that's what our competitors were also offering. So, we had no choice but to make our products noncancellable as well. Although, if we did have a choice, we would have certainly made it guaranteed renewable.

We then had to decide which illnesses to cover. We knew we had to cover the big four, namely heart attack, stroke, cancer, and coronary artery bypass surgery. We chose several others that we knew were both significant emotionally and that created substantial financial problems for its victims. In total there are 15 insured conditions, making it one of the most comprehensive products in Canada.

We then had to get down to the task of pricing and assumptions. The morbidity assumption was our major concern. For that, we partnered up with a reinsurer, which had conducted significant research into the product and committed resources to supporting critical illness.

The Canada Life also had actual U.K. CII experience internally and pricing knowledge in our UK operation. In addition, we had a South African actuary, David Fihrir, who joined us in Toronto for this project. David's former employer was Crusader Life, the company that first launched CII to the world in a significant way.

We then began the arduous task of drafting our contract wording and definitions that both Canada Life and our friendly reinsurers would agree to. Since CII is a new product, we had to decide if the contract should be written in accordance with Accident & Sickness (A&S) provisions or life provisions. Since stand-alone CII really has nothing do life insurance, we decided to use A&S language.

We then had to prepare applications that were consistent with the coverage we were offering and ask the appropriate questions such as family history questions.

Our medical staff contributed to the wording of the contract by providing definitions for the various insured conditions. Our reinsurer also played key roles in training our underwriters on how to underwrite CII.

Canadian CII claims experience is limited. We had to rely on foreign data, reinsurer support, and good common sense to establish underwriting guidelines for this product.

We knew that the marketing of this product would be very different from life insurance product marketing because we had to educate both our brokers and the general public about the concept. The challenge lay in convincing people that the risks of critical illness and the corresponding financial impact were real.

The success of marketing CII lies in being subtle but effective in delivering a message, which focuses on the need for the cover, while at the same time not promoting it as a lottery. The last thing in the world that we wanted was to promote get-rich-quick-type advertisements. We wanted our marketing pieces to not only mention the risk of critical illness but also stress the very favorable odds of survival. The focus was on the needs of people who survive critical illness, since critical illness is insurance for the living.

To deliver this message, the expert testimony of heart surgeon Dr. Marius Barnard was used. Dr. Barnard is widely recognized as the father of CII.

Dr. Barnard would regularly see patients survive heart attacks and bypass surgery but would also see their financial lives devastated. He decided to do something about it. He lobbied the various insurance companies in South Africa to develop some sort of product to deal with this risk, and thus CII was born.

The Barnard tour captivated our brokers throughout Canada and received very favorable press coverage.

As a follow-up to the Barnard tour, Canada Life undertook to train its producers to position CII appropriately. The training programs are still going on, so I have no conclusive data to share with you regarding their ultimate success. All I can say is that it does look promising.

Finally, Canada Life has also committed itself to continuously promote and modify it's products so it can keep the attention of its brokers and continue to be the acknowledged leader in the market.

What lessons have we learned? The most important lesson is if your company wants to enter this market, commit significant resources to its success. The best way to fail is to dabble at it.

In summary, given the reaction we've had with some of our internal staff, I think you have to put together a product development team who's dedicated to the product's success. Even if you do have some CII knowledge internally, partner with a reinsurer to get expert advice and support. Finally, your marketing material should focus on the need for coverage and stress the message that this is insurance for the living.

If the market doesn't exist, then make it and promote aggressively. Remember that your brokers may be unfamiliar with this insurance, so you'll have to educate them about the need for CII in general, as well as the workings of their product in particular. Producer education and training is a must. Finally, continuously promote and innovate, as it's the best way to take a leadership position in the growing market.

So, although the market for CII in Canada is still in its infancy, we're hopeful that it will have a bright future.

Mr. Tony Boston: I didn't like the way you call it CII. I like CI, because CII to Englishmen means "charge to the insurance industry" and nothing else.

One slightly more up-to-date thing is that the Institute of Actuaries in England has actually set up a working party on critical illness to try to collect experience there. As you rightly said, the major advantage of the policy is flexibility since it can be adapted to any market you like. The only thing I would argue with is the wisdom of a 25% benefit for angioplasty. While I appreciate it's a limited benefit in Scott's relatively low-amount product, in other situations where say the face amount is $1 million, you could pay out $250,000 for what is in my mind a relatively noninvasive procedure. Where do I sign? This is something where I can split the cash with a doctor to do it!

Mr. Howell M. Palmer: How do you determine the amount of coverage for someone, and what kind of underwriting do you do for the larger amounts?

Ms Patteson: If you're referring to what sort of amount of financial underwriting would occur, 2–3 times income is appropriate. Most underwriters are pretty uncomfortable going much higher than that, but it's an area that's in its infancy, and I think we're learning as we go.

Mr. Luchesi: I would just add that the 2–3 times income rule is reasonably well accepted, except I believe that you can also add the amount of your outstanding mortgage to that. As far as underwriting, obviously that would vary from company to company. At Garden State, we do full medical underwriting at $100,000 and over, which may include attending physician statements, blood tests, and, if appropriate, inspection reports and financial background. Obviously, if you're going to have a paralysis benefit, you're probably going to run a lot more motor vehicle reports than you might otherwise run, but other than that, CII underwriting is very similar to underwriting for large amount life insurance, with much more emphasis put on family history issues.

Mr. Barry Eagle: A quick question for Scott. Given that the difference between the worldwide market experience and the American experience seems to be that we have a bigger uphill battle against the regulatory environment, do you see that as something that is within the departments themselves, with the insurance commissioners, with attorney generals (as in Connecticut), or perhaps with consumer groups in California? I know the easy answer is all of the above but please give your opinion.

Mr. Luchesi: Since my filings are still pending in a number of states the best I can answer is that we've had a real struggle with the product since it just doesn't fit any of the parameters that the insurance departments are dealing with. There's a lot of back-and-forth correspondence to try and convince them that it is a valid coverage. I think this particular product also has a little bit of a battle to overcome because there's somewhat of a stigma attached to the old cancer insurance, and there are a lot of departments that look at it as just another version of that. There's a serious learning process that the departments have to go through, and the best I can say is that some departments are more willing to go through this than others. With some departments, you can make the best argument in the world, but they just don't have the regulatory authority to actually approve it. There are some provisions in the regulations that say it doesn't prohibit the product, but it doesn't allow it either.

Mr. Alistair Cammidge: Looking at this from the point of view of the pricing actuary, the prime problem seems to me to derive some incidence rates for cancer, heart attack, and stroke, which are applicable to American insurance. Now, we have experience applicable to foreign insureds, and we also have population data, the Surveillance Epidemiology End Result study, applicable to cancer population incidence rates in this country. The problem seems to me to lie in heart and stroke incidence rates. We do have the Framingham study, but it is somewhat out of date and has a number of technical problems. I have seen some very interesting work done by a South African actuary with another reinsurer on how one can derive critical illness incidence rates from cause of death rates and survivorship rates, but I

would like to ask the panel how they would attack the problem of deriving heart attack incidence rates applicable to U.S. insured lives.

Ms. Patteson: There are certainly limitations in terms of available data from which to work. I am afraid I am not equipped to get into details of exactly what studies we used in the development, but my colleagues at Swiss Re seem to feel some comfort at the end of the day that they can derive incidence rates from their investigation into various studies, which include the Framingham heart studies.