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Session 7PD
New Forms of Individual Disability Products

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Summary: Panel members explore new disability products offered by writers of individual disability insurance and the ways in which these products connect with other types of insurance. Specific subjects include connections to long-term-care insurance, critical-illness insurance, and injury-only and special-risk products.

Panelists discuss their own experiences in designing, pricing, and marketing individual disability products that go beyond the traditional approaches to this market by linking disability with other forms of insurance coverage.

Mr. Robert Beal: In an insurance line of business, which often is characterized by commodity products, this is a very welcome session and should be very interesting.

The first speaker is Jena Breece from UNUM. Jena will talk about market expansion to middle-income individuals and packaging individual products with group. She'll be followed by Lisa Forbes from Aetna Canada. First, Lisa is going to give an overview of the Canadian disability insurance (DI) market, then talk about the Health Flex product for the non-conventional workforce, and, last, talk a little bit about a product her company has had for well over ten years now, Income Plus, which is an interest-sensitive DI product. The third speaker is Raza Zaidi from CNA, who's going to talk about CNA's new DI program for the association group DI market.

Ms. Jena Breece: I'm the individual disability actuary at UNUM, and I'm going to be talking about DI product innovation in terms of some new products that UNUM has rolled out in the last six to eight months. We are in the final stages of merging with Provident, but I'm going to restrict my comments to UNUM, because that's what I know the best.

Just to frame up historically what has happened over the last ten years in the individual DI market, there were a lot of problems in the early 1990s; it was a blood bath. Much of the product innovation that happened in the mid-1990s was in

reaction to that, and solutions varied among companies. UNUM's solution was to go with a guaranteed renewable product to provide a safety valve in case any other big disasters appeared on the horizon. More important, UNUM made it a loss-of-earnings contract to avoid the true-own-occupation-to-age-65 issues that we had seen before. Although there was a lot of innovation and changes going on in the mid-1990s, it was mainly directed at a similar market. Granted the market has fewer attorneys and more executives now, but it's still the upper-income, white-collar market.

Now that those products have been shored up, hopefully for good, we're looking at new places to go, because if we're really going to be a growing, viable industry, we need to expand beyond just the upper-income, white-collar market. UNUM's approach has been to go with more "acceptable" products. By acceptable, I mean products that are available to a larger variety of occupations and income levels, are more convenient for people to buy in those income levels, and are flexible enough to allow us to meet a lot more needs with fewer products.

Another tack that UNUM has taken is to coordinate with group long-term disability (LTD) coverage, which is a natural set for UNUM, given the size of our LTD line. We had substantial growth in selling an individual DI package with group LTD, but the main product I'm going to talk about today is the new middle-income product UNUM rolled out earlier this year. The goal was to expand the market to make the product much easier to purchase, as well as more flexible. Approaches to tapping this market in the past have been varied and companies have seen various degrees of success. There are limited benefit plans out there, some as short as two years. One of our subsidiaries, Colonial Life and Accident, has been successful in selling an accident-only critical-illness product, which I know Provident has also used. And, there's the traditional DI approach, which hasn't worked particularly well, although it could fill the gap in some of those cases, but not all of them. As a result, there’s an opening for a product like UNUM’s Essential Disability Protection (EDP) to provide a broader coverage to this market.

The way we seek to expand our market with EDP is to target middle-income individuals earning $30,000–80,000 a year. Our white-collar LTD product is focused on the $100,000 and higher market, so we're dropping the income targets substantially. We can do bottom carve-outs with this product. It's probably more of a secondary market, but if we have our white-collar product for the executives, we can offer EDP to the middle-income portion of a particular group. For example, our group LTD voluntary plans require a minimum of 15 lives to sign up, and a participation percentage of 75%, grading down to 25% at 100 lives. You can see there might be a lot of cases that can't muster that number of lives or that participation level, so it's really not much of a solution for them if the employer doesn't want to pay for the coverage. EDP fits very nicely there because we only need three lives to sign up, and there's no participation requirement so there's a big gap that our voluntary LTD leaves that we can fill with EDP.

We did a lot of work to try to make it easier to purchase, because people in the middle-income market may not be aware of the risks that they've assumed when

they don't have individual insurance. There have been lots of surveys that say people really are interested in buying these kinds of products through their work site. For our purposes, the higher participation means a better spread of risk and lower costs. So, if we go into a work site and sell it, we might get a lot of people to sign up who really hadn't thought about it in any other capacity.

We worked on simplifying the enrollment because we wanted to make the process easy for the employer and the employees by simplifying the application. It is less daunting than our white-collar product application. We also simplified the occupation classes. It might not be obvious why you would need to do that. Our white-collar product has an occupation guide that shows the class for each occupation. However, it's not clear-cut as to exactly what each occupation does and what the duties are. A "retail manager" can mean a lot of different things, ranging from somebody who works at L.L. Bean or Eddie Bauer to the manager of a grocery or video store. And there can be a lot of different levels of manual duties, etc. So we came up with an occupation-class system that is based on one's income, the percentage of manual duties, and the percentage that one travels. It's objective and easy for people to figure out where they fit, and it helps us ensure that we're putting people consistently into the right risk classification.

Another big focus with this product was simplifying the underwriting. We didn't want it to be a big, daunting process. More important, because the product will be sold through payroll deductions, the payroll deduction starts for everybody on the same day. If we have two or three people left hanging out there because their underwriting decision isn't final, there's a big administrative hassle that we want to avoid. We did things like looking more to the accept/reject decision. With our white-collar product, we tend to try to figure out how we can write coverage on this person through whatever combination of plan changes, exclusions, or substandard ratings that we need to put together to make it viable. With EDP, the decision is to accept or reject. For example, we don't intend to get many attending physician's statements (APSs) with this product, relying much more heavily instead on inspection reports.

We're using broad exclusions. If somebody has had back problems, we would exclude perhaps the whole back to speed the decision; with our white-collar product, we might exclude only certain vertebrae. We're not using any substandard ratings, partly due to the administrative issues in terms of payroll deduction, and we didn't want to get into bait-and-switch situations where we send somebody an enrollment package and it says, "Here's your rate," and when they go through underwriting, we would say, "Oh, sorry, it's higher." We wanted to avoid that situation.

Now that we're giving up a lot of underwriting, we need to look at the basic pricing and, second, we put some risk controls into the product to make sure that we weren't giving away too much. For example, we have stripped the product down to make it less rich than our white-collar product, which leads to the simplified product design. We put in a total definition of disability, whereas in our current white-collar products we use a proportionate-loss formula when someone is

partially disabled. We don't have that with EDP. Instead, if you can't do the material and substantial duties on your own, then you're disabled; if you can do any of them, then you're not disabled, so it's a much more restrictive definition.

The second thing we did to rein in the cost was to add offsets. It looks like a hybrid individual/group product, where we offset for Social Security, workers' compensation, state disability, and earnings. And, last, we tried to make the design very flexible, so we went with a stripped-down, simple base coverage with quite a few riders. Therefore, if someone wants additional coverage, they can get it. For example, we have a rider that changes the total disability definition to a partial disability definition for the first 12 months. And they can also buy our Activities of Daily Living (ADL) coverage if they want to increase their coverage. There is also the standard Future Insurability Option (FIO) rider.

That's all I'm going to say about EDP for the moment. I also want to briefly mention some new riders that we rolled out late last year. These are attached to our white-collar product. The reason that I mention them is that each one of them in some way, shape, or form helps us package more effective group coverages.

The prime example is the work-incentive benefit. This has been a standard feature in our group LTD contracts for many years now, and we're just now bringing it over into the individual world. What it does is, in the first 12 months of disability, if someone returns to work part-time but is still disabled under the definition of the contract, instead of paying the person the proportionate benefit that we would normally pay, we pay the difference between his or her prior earnings and current earnings. This rider encourages people to get back to work.

We recently added a mental-nervous extension, which removes the two-year mental-nervous limitation. Again, that facilitates packaging in terms of a group plan that has limited mental-nervous, but I have to say that we're being fairly careful about whom we give that out to. For example, we wouldn't give it to a doctors' group.

Last, we have a recovery benefit, which facilitates packaging because it's something that none of our group LTD plans have, so it might be an incentive for somebody to write some of our white-collar products on top of their LTD. The way the recovery benefit works is, if someone has returned to work full-time and is no longer disabled under the terms of the contract, but the person has lost an income or part of his or her income because he or she depends on having a client base, we pay a proportionate benefit for one to two years, depending on which option the person buys.

I'm going to talk about some pricing considerations. The first one, data relevance, is something that applies to all of the products that we're pricing. Probably most of you, like UNUM, have a vast majority of your DI experience in noncancellable LTD, the old-style disability contracts. We certainly hope that this experience is not predictive of our future experience, so we have to make a lot of adjustments to

that data in order to be able to use it for pricing. We adjust for the contract provisions that have changed and target markets that have changed.

Another thing you need to think about with a middle-income type of product is the demographic mix, because we should expect more younger and female applicants.

Because underwriting is greatly simplified, we have implemented some risk controls. We had to figure out what the changes were either costing us or buying us in the pricing. We expect expenses to be quite different with this product because the underwriting is so different, and we're not getting the blood tests and the APSs. The underwriter should be much more productive because these policies should be much quicker to underwrite. The underwriter should be able to handle a lot more of these than our traditional product, which we factored in. However, we also had to add some enrollment expenses because it's work-site-marketed and we do a lot more enrollments.

The bottom line is, we have a vastly underpenetrated disability market. There are lots of people out there who are uninsured or underinsured, and many of them don't even realize that they've taken on this risk. The future of individual DI product development should be aimed at figuring out a way to get products to those markets.

Ms. Lisa Forbes: Aetna Canada has been known in the Canadian DI industry as an innovator for disability income products, and I'm happy to be here to share a few of them with you. My presentation will focus on three main areas. First, I will give an overview of the Canadian living-benefits marketplace, and talk about the recent activity regarding the development of products for the nonconventional workforce. Next I will move to our product, Health Flex, which is our way of dealing with the nonconventional workforce. And last, I will discuss our Income Plus product, which is the only interest-sensitive disability product in Canada.

The experience that we have seen on our DI morbidity has not been as turbulent as it has been in the U.S. For example, in Canada, we haven’t seen problems with traditional DI products. Also, there has been a lot of consolidation among the carriers in Canada. It started with the Revere-Provident merger, followed by the acquisition of Crown Life by Canada Life, and then the UNUM-Provident merger. The one that hits most closely to home for me is the acquisition of Aetna Canada by Maritime Life, which is still subject to approval. To give you a sense of the size of the Canadian industry, in 1998 noncancellable DI sales represented $45.5 million, and, in the first quarter of 1999, compared with the first quarter of 1998, sales are up about 14%. This is remarkable when you consider that, a couple of years ago, the industry was down by about 10%.

We've seen exponential growth in critical-illness products in Canada. For long-term care (LTC), there has not been a lot of growth. Right now there are only three carriers selling it, because the Canadian population is generally unaware of the need for LTC insurance with respect to nursing-care facilities. I'm sure it also has a lot to do with demographics. Right now, a lot of our population is in the boomer

generation. As these people start to age, they will begin to see the need for LTC insurance. I also expect the government will start to cut back on LTC benefits as well.

Let's look at an overview of the key players in Canada. Provident-Paul Revere and UNUM have approximately 50% of the market share. Second is Great West Life, and the third spot is a race between Aetna and Canada Life, which have approximately 14% of the market share. A lot of the activity over the last couple of years has been the development of products for the nonconventional workforce. When we talk about the nonconventional workforce, we're talking about four subsets of the population: new business owners, home-based workers, seasonal workers, and part-time workers. Traditionally, these groups have been ineligible to purchase disability products in Canada.

The typical design of the products offered by most carriers is a cancellable policy. There are exclusions for mental-nervous, alcohol and drugs, and soft-tissue injuries. I know, for example, that 1 contract limits payments of back claims to 30 days. The base plan on these contracts usually only offers coverage to age 65 for injury-only. You can enhance the base plan by adding sickness coverage, but the coverage is usually limited by a short benefit period. Usually, no financial underwriting is done at time of issue, most of it is done at time of claim, and the rates do not vary by occupational class. I think the target market for this group is mostly the blue-/gray-collar market, and, as a result, the premium rate would resemble an A class rate.

Health Flex is Aetna's approach to the nonconventional workforce, and it is very different from what the other carriers are offering. It was introduced early last year and was designed specifically for two subsets of the population: new business owners and home-based workers. To qualify for the product, you have to earn a minimum of $15,000 per year and work at least 30 hours per week. We expected that new business owners would not have the financial documentation necessary to qualify for the Health Flex product, so we automatically issue $1,000 of monthly benefit. We do have distinct rates for occupational classes, unlike the other carriers, because our target market is mainly white-collar new business owners: computer professionals, software developers, and occupations like that.

When we were developing Health Flex, we had three main objectives. First, we were committed to the noncancellable product design because that's what our brokers wanted, and we have had success at Aetna with the noncancellable product design. We also weren't comfortable offering a product filled with automatic exclusions and limitations because, although these claims are subjective, there are very many legitimate, severely debilitating claims. Also, we wanted to offer long-term sickness benefits in our Health Flex plan.

Health Flex has a component structure. The first component is the base plan that offers injury-only protection. You can then enhance the base plan by adding the sickness-protection rider. If you are a new business owner and purchase the sickness-protection rider, there is a conversion rider available that enables you to

convert within three years to a traditional disability product for more established business owners. There's a range of riders available: pension guard, cost-of-living adjustment, premiere-mason rider (which I'm not going into any detail about), and a critical-needs rider that offers critical-illness protection.

I'm going to focus on three components of Health Flex: the injury-only, the sickness rider, and the critical-needs rider. The injury-only plan offers 24-hour protection from disability due to injury both on and off the job. There is a one-year regular occupation period, so the definition is "the inability to do substantial duties in the first year." After that, there is an any-occupation definition. There are several built-in features available on Health Flex. There's a partial benefit available, waiver of premium, and rehabilitation benefit; there's also a nonoccupational disability definition, which is a prize to people who are on sabbatical or maternity leave and those who are unemployed. This definition of disability is based on the inability to do the activities that they're doing while they're on leave. There is a relationship-to-earnings clause that ties the amount payable to the insured's predisability income; after that, we integrate dollar-for-dollar with benefits payable from the Canadian pension plan as well as from workers' compensation.

The sickness-protection rider also offers 24-hour protection. There are built-in partial benefits and there is a one-year regular occupation period similar to the base plan. After the regular occupation period, benefits will continue if the client meets any one of four indicators of functional dependence. The indicators of functional dependence were developed jointly with our reinsurer, and they're very similar to the ADLs that you see on the LTC contract. There are four categories: self-care, transfer mobility, cognitive ability, and terminal illness.

The self-care category measures the person's inability to take care of himself or herself, so we look at activities such as eating, toileting, dressing, and bathing. To qualify, you have to be unable to do two of the four activities. Then there's transfer and mobility, which measures the person's inability to move and get around. To qualify here, you have to be unable to do two out of three of the activities. Then there's cognitive ability, which measures the person's ability to function in society and deal with day-to-day functions such as health care, mental awareness, finances, and communication. To qualify here, you have to be unable to do two out of the four activities. The final category is terminal illness. This was added because, after looking at the ADLs, we felt that there may be some sicknesses, for example, cancer and HIV, that wouldn't qualify under the three out of five. So this category was added to pick up some of them. Here, the category is a diagnosis of a terminal illness, coupled with a short-term prognosis as well.

I would like to review some of our pricing considerations when we were developing the sickness-protection rider. We first used the Commissioners Individual Disability Table A (CIDA) table adjusted for our experience. Then, to determine the termination after the first year for the regular occupation period, we did an analysis of our long-term open claims to see what percentage of them would still be around and which ones would meet the IFI definition. Based on that, we assumed about 30–40% percent of usual continuance following the 1-year regular occupation

period. After one year, we assumed terminations are only substandard mortality, and that's because of the very restrictive nature of the definition on the sickness-protection rider. The female premium loads range from 15% to 60% of the male rate. Smoker loads are about 15%; however, on our recently priced products, that was increased to 20%.

The critical-needs rider that offers critical-illness protection was added because, at Aetna, we feel that critical-illness insurance is a complement to DI; it's not a replacement for DI. Often when people are diagnosed with a critical illness, their expenses go up and they need the lump sum that's payable to cover the extraordinary expenses they incur when they're diagnosed with a critical illness. This means that they can also reserve the monthly benefit available on the disability plan for the day-to-day expenses. On our critical-illness rider, there are 12 covered conditions. A lump sum is payable if you're diagnosed with 1 of these 12 covered conditions; however, you do have to survive the waiting period. Typically, the waiting period is 30 days; however, for some conditions, for example paralysis, it is 180 days.

Now I'm going to talk about Income Plus. Income Plus is not a new product. It was introduced sometime in 1985 by Aetna, but because it's the only intrasensitive DI product in Canada, I thought you might be interested in some of its features. Just to give you an indication of sales, in 1990 Income Plus represented 53% of Aetna's sales; last year, it represented less than 1% of our sales. I think this is largely due to the change in the interest-rate environment. In 1990, interest rates were declared on Income Plus around 10%; now they're in the range of 5%. Also, in the last couple years, because we have not seen significant sales on this product, a lot of our pricing activity has been focused on other products within our portfolio.

The Income Plus product offers excellent disability coverage similar to what you see on other traditional products offered to the professional market. There are total and residual disability benefits, and death and recovery benefits. The product has a range of elimination periods and benefit periods available, and it's available to the same occupational classes as well.

Income Plus is a very complex product. I'm not going to go into a lot of detail on the mechanics of it, but instead discuss a few of the features that are very beneficial to the client. The equity date on the Income Plus policy is the date when the company reserve account turns positive. What determines that equity date is the initial premium. The client has the opportunity to choose the initial premium anywhere between a minimum and a maximum range, and the equity date happens anywhere between the second and the fifth policy anniversary. Prior to the equity date, the policy functions just like a traditional product, so the initial premium is set. This is a fixed premium until the policy reaches the equity date. After the equity date, the product becomes unbundled and goes into flexible-premium mode.

In its simplest terms, the mechanics of Income Plus function like a bank account, where the company reserve account is the bank account. Each month, premiums are deposited into the account, insurance and expense charges are deducted, and

interest is credited. As long as the reserve account remains positive, the policy stays in-force. Once it becomes negative, the policy is in a lapse situation.

One of the main benefits of Income Plus is the opportunity for clients to vary their premiums according to their financial situation. At Aetna, we don't have step rates. Therefore, if new university graduates, for example, don't want to pay a high premium, they can choose the initial low premium, which will be set for five years and then the premium will jump up after that, depending on the interest rates. Also, if there's enough value in their policy, they have the opportunity to go on premium holiday.

There is also the opportunity for clients to prepay their coverage in as little as five years, and this can result in significant savings. Just like any other universal life (UL) plan, they can increase and decrease their premiums. The unearned premium value on Income Plus acts like a surrender value. It's available at death or surrender of the policy, and it represents the amount of unused premium after the equity date. This is beneficial to the clients because, in Canada, there are no tax laws relating to disability, so they're not subject to the accrual taxation that you see on a UL plan. The insurance charges are YRT morbidity scales, and these are guaranteed. The expense charges are fully guaranteed, except for government premium taxes, which vary by province in Canada. The interest rate is not guaranteed; however, there is a minimum interest-rate guarantee on Income Plus of 4%.

What will the new forms of the future look like? I don't know. We feel that the new product of the future will be a combination product. What I mean by a combination product is a UL chassis with riders for disability, LTC, and critical illness on top of that. I don't know if the product will function as a trigger product, where the event that takes place in the client's life will trigger the benefit payable. For example, if you look at paralysis, more than likely the definition of disability will be met, so the disability benefit will be paid. If the person is severely disabled and requires nursing care, the LTC portion could be triggered as well. And, if his or her paralysis is one of the covered conditions under the critical-illness policy, that could be triggered as well.

There are a range of challenges with these products. One that comes to mind is how you integrate it into your system. Also there are valuation concerns because a lot of tax and legislation that applies in universal life might not apply in disability. And, of course, there are the underwriting concerns, such as overinsurance and issues like that.

Mr. Raza Zaidi: I'm the pricing actuary under CNA's association market disability block, also known as the association group market. I'm going to start with giving you a quick overview of the current association block at CNA.

The associations we deal with are either the large national ones or pretty substantial state associations. The primary focus of the contract (and this should be absolutely no surprise to anybody) is white–collar individuals. The majority of our business has come from takeovers, and there are some very serious

shortcomings in the takeover contract that have resulted in some very serious profitability issues. These issues have been translated into growth issues because we have to fix the profitability before we can go further. Some of the shortcomings that we identify in the contract include claim-management language, which is almost nonexistent. Definitions and provisions are very rich.

The ability to change provisions, rather than the rate, doesn't exist because of the terms of the contract. We have no idea from where we got the pricing because it's been from takeovers. You can't go back and say the original morbidity basis was 85 CIDA, 64 Commissioners Disability Table (CDT), or whatever because there's no connection. So, profitability and growth are the issues we've tried to address in this new product. We identified what we needed to do to meet these goals. Some of these needs address the profitability issue, and some of them address the growth issue.

To support effective claims management in this new contract, we have tried to bring in provisions such as mandatory rehabilitation, which means that if the claimants do not buy into the rehabilitation plan, then their benefits can be terminated because the emphasis of the contract is to get the claimant back to work. This provision comes from the group-disability side of the business. It's helping claimants get back to work without taxing them with a financial strain that they would experience in the earlier parts of their disability.

Limitations for mental-nervous, substance-abuse, and self-reported symptoms have been done on the group side very effectively, and we want to bring the same things into the association side. Requiring objective medical evidence from the claimant to continue the claim goes a long way to terminating the claim or at least getting into a position to negotiate with people and say, "The medical evidence is showing that you are getting better, so let's talk about going back to work; we'll help you along, but let's get back to work." We are also working on work-site modifications. If you have a back disorder, for example, and we can bring in a new chair that gets you back to work, then let's do it. To address any overinsurance issues, we would like to offset with the individual and the franchise coverages that you may already have.

Why was there a need for new pricing? My best guess is that the pricing on our current block came from somewhere in the 1980s, which represented a double-digit interest environment. It also represented a different morbidity pattern. Back then, a mental-nervous disability had a stigma attached to it. That is not so anymore, and we have tried to allow for that in the pricing. We also wanted to simplify the pricing structure to get away from the rate-book approach, where you have a dollar premium rate per $100 of benefit. On the optional benefits, the basic benefit still has the same rate-book approach, but all the subsequent benefits are a factor applied to the basic benefit. There are some new benefits that we're going to be offering, which provide some equity to the underlying insured. We'd like to offer the gender-rating and tobacco-usage rating.

Flexibility is needed in setting the different definitions of disability. For a low-risk occupation, you may be willing to go to a five-year own-specialty definition. For a more high-risk group, you might want to limit it to a two-year own–occupation, and any occupation thereafter. Not only could there be some groups that are high-risk, but the financial situation of the underlying group (i.e., the amount of money they can afford to spend on DI), may also be a concern. For this type of group, we came up with a two-year own-occupation, followed by a requirement of two of six ADLs (the LTC concept). This reduces the cost quite substantially on an LTD contract. We coupled that with effective underwriting guidelines by limiting coverage by issue ages. There's a harmless benefit you can buy if you're under a certain age, and we can also limit elimination-period choices. You probably won't want to do a short elimination period for some of the very high-risk groups because the cost and the risk will be way too high. You should monitor the replacement ratio limits, look at how much people are buying at the time of underwriting, and not offer them more than a certain number of benefits. All of these considerations put together will give us the flexibility to write different types of risk.

The complete product portfolio has a short-term plan and a long-term plan. The short-term plan is a short format. It's inexpensive to underwrite, and the policy issue expenses are low. It gives a choice of benefit periods. Although there's a choice of elimination periods, when you're actually marketing this plan, you'd want to limit the elimination choices to one elimination period because, once again, if you start giving too many choices, then expenses become an issue. The amount of premium you're going to collect on a product like this is not going to be high because the benefit amount is very restricted.

The long-term plan has the long format with a comprehensive health questionnaire to address the antiselection issues, four benefit periods, and five elimination periods. Once again, we can restrict some of them because we may not want to offer a 45-day elimination period to certain occupation classes.

At CNA, we have identified the need to bundle this product with the other products where we have a substantial market presence. For instance, the LTD contract, which will be the underlying base contract, can now have a business-overhead rider. Instead of a stand-alone plan, it's a rider that goes right on top of the base LTD coverage. We're also building a LTC policy within the LTD plan, and I'm going to discuss that a little later. You can also purchase accidental death and disability (AD&D) insurance from CNA. You purchase this benefit by checking it off on the application for a certain amount, such as $10,000 or $20,000 AD&D.

If you're in the association marketplace, physicians and other health care professionals are definitely a market you will need to consider. We at CNA realize that health care is a lucrative business. Physicians do command big benefits. They have the buying power and can pay for it, but they also come with a unique risk. If you don't understand how unique that risk is, you will sustain very sizable losses and exit that market. In recent years, we've found that to be very true.

For CNA, the risk was no different from the rest of the industry, initially. We invested a lot of resources to develop the knowledge and ability to underwrite these risks successfully. We did that by looking at the pricing and the morbidity on an underlying morbidity basis using specialty factors. The contract recognizes specialties and subspecialties at the time of claims adjudication. This becomes a very crucial issue. The claim management process itself uses professionals with clinical experience. We establish protocols according to specialties, the work environment, and benefit plan, and we use different types of payment options to deal with the underlying claimants. We could settle a claim by offering them an amount that is a portion of their outstanding claim reserve, or we could work with them and develop a financial rehabilitation plan where we won't offset the benefits initially while they're trying to get back to work.

We recognize that certain disabilities are catastrophic in nature. They require more financial support than the average disability because of the claimants' special needs. We define catastrophically disabled as the inability to do two out of the six ADLs (which the LTC people have as a standard definition in their arena). Somebody who is disabled at the catastrophic level will need extra care. For instance, they might want to get somebody trained as a caregiver, or they might want to have some emergency-alert system installed. Under our plan, if you're disabled, you can either get a lifetime benefit (because, if you're young and get disabled catastrophically, chances are that you're going to need a benefit to take you right through your entire lifetime), or, if you're disabled after that particular age, then we can give you extra indemnity, which is about 20% more than we're going to give you because you're going to have certain expenses. At the older age, you may have taken care of your retirement plans, so the extra indemnity will help you overcome some of the immediate financial needs from the catastrophic disability.

I like to say that there's a common tale for disability plans: The insured either lapses the policy near retirement or attempts to use it as a retirement plan. At CNA, we came up with an alternative. After the age of 55, we can offer an insured an LTC fully-paid contract, or they can come in and purchase a fully underwritten LTC contract after turning in their disability policy as a coupon. They receive a big discount through a conversion option. They prefund this particular optional benefit through the life of the policy, and, at the end, we use the reserve that's been built up to provide the guaranteed-issue, paid-up contract or provide a discount on a fully underwritten contract.

As with any product, you need bells and whistles. Some of these are unique because they're just coming out now in the disability arena. The rest are the traditional bells and whistles that have always been included in disability contracts.

A business overhead-expense policy becomes an optional benefit if you're not buying DI as a stand-alone policy, but as a rider, which is a newer approach to selling that benefit. The double-indemnity survivor benefit pays when the insured is in an accident and dies. The survivor gets two times the benefit. I've already talked about the catastrophic-disability benefit.

A newer optional benefit available now that hasn't been around for very long is the right to convert to an LTC contract. Because CNA has a substantial market presence in the LTC arena, we can offer an LTD contract and build in this LTC conversion. That is not being done by too many carriers, and we find that the only carriers that can do that effectively are the ones that already have an LTC presence in the market.

The rest of the options are your traditional benefits that you'd find with the LTD policy. The HIV benefit is geared toward the health-care professional market, where some health-care professionals might lose their licenses to practice if they're diagnosed as HIV-positive. The college loan repayment benefit (I wish I had one of those) is for those young professionals—dentists, doctors, and attorneys—with substantial college loans that they are liable for. In case of disability, we pay a certain portion of the loans.

Mr. Beal: We have time for some questions, comments, other ideas. Anything you'd like to offer up would be welcome.

Mr. Michael J. Prager: This question is directed to Ms. Forbes. I'd like you to comment on how the trends in the legal environment in Canada have affected your product design and your experience. The countries are very different in a number of areas. You mentioned one trend in your presentation, which is post-claims underwriting. The countries are getting closer together these days; unfortunately, Canada is getting closer to the U.S., and I'd like to know what you're seeing in your experience, and I'd also like to know what you're doing in product design.

Ms. Forbes: Our experience over the last few years has continued to improve, both on the incidence side and the termination side. It's not only just because the experience is improving, but we do have some riders in our portfolio, one being the premium-refund rider. This pays a refund of premiums if the client does not claim over the eight-year period, and that has helped us dramatically. Also, we have made financial documentation mandatory on all of our clients when they're submitting an application, which has also improved our experience.

With respect to legal considerations, there have been some court cases in Canada that are turning an own-occupation definition into a regular-occupation definition. I don't have enough knowledge on that subject to comment a great deal on it. As for the product design, again, most of the carriers are focusing on cancellable products; they're not doing a lot with their noncancellable products, except for doing rate decreases across the board and things like that. A number of carriers are getting into critical illness; in fact, almost all of them are. One of the banks in Canada, a trust company, introduced a creditor critical-illness product and issued more than 600 policies in the first week. So that product is becoming very popular in Canada, and I expect that, in the next few years, you will see a number of companies developing LTC products because they feel that is the product of the future.

From the Floor: I have question on the two-year illness benefit. What happens if the claimant lives beyond the one year?
Ms. Forbes: Under the terminal-illness category, if the adjudicator feels that someone is diagnosed with a terminal illness and there is a short-term prognosis, we will continue to pay the claim. We wouldn't say you're cut off after one year. This is a brand-new product for us, and I'm sure that may change down the road as well.

From the Floor: My question is directed to Mr. Zaidi. You mentioned converting disability coverage to LTC coverage after retirement. When did CNA start this and what has the response been?

Mr. Zaidi: We have just incorporated that provision with our millennium series and are just now going into the market. We have done some ad hoc surveys and polled some of our brokers. The response is tremendous from the broker community on this particular option.

Mr. James T. O'Connor: Jena, in terms of your simplifying the underwriting, you described how you also limited your benefits. In terms of your ratings, what kind of antiselection or adverse selection provisions have you put into your premium rates to counter that expected antiselection?

Ms. Breece: First of all, we tried to account for it in lots of places. If we had only accounted for it in the pricing, it would have made the product unaffordable for the market. So we did a lot of things like putting in the preapplication, stripping the contract down, and putting in provisions like the offset. We set the pricing structure up so that it was based on participation, so that the higher the participation level, the bigger the discount, which encourages more people to buy. The remaining question is how much we've given up net in terms of risk selection. I don't want to discuss absolute numbers, but I will say we put in a significant load for the underwriting piece. We were initially hoping that the price would come out to be lower than for our white-collar product, but, depending on what occupation classes you compare, the prices are similar. For some options, they're a little bit higher on a per $100 basis for the middle-income product and a little bit lower for other options. We didn't think that would be a huge issue because, in absolute dollars, the price will be lower because people are going to be buying less coverage.

Mr. Beal: Jena, could you clarify one thing on the underwriting? Did you say there will be no blood testing?

Ms. Breece: Yes, I did, no blood or urine testing.

Mr. Beal: Blood testing originally became popular because of the AIDS risk. How do you account for that?

Ms. Breece: The way that we priced for the lack of blood and urine testing was by looking at statistics we had on the preventive quality of a blood test.

Mr. Clifton Arthur Stone: My question is directed to Ms. Forbes. In Canada, you've seen a lot of growth in the critical-illness area. Do you see the market in two parts: a lower-sized market and a fully underwritten part? Do you see the interest more in one area or the other, or do you see both just going very strong?

Ms. Forbes: The question was, where do I see the growth in the critical-illness product—the low underwriting or the higher amounts of full underwriting? Right now, in Canada, the average size for a critical-illness product is $100,000. Some carriers are issuing in the neighborhood of $2 million, but that is for the business market. There isn't a lot of growth in that market right now. I see a lot of the growth continuing with the smaller-sized products on critical illness. When you're looking at a combination product of disability, life, and critical illness, I even think that $100,000 may be too high. An amount in the neighborhood of $25,000–50,000 would be more appropriate. Also, the product is not cheap. So, when you're looking at the premiums for the disability plan and then running them out with critical illness and LTC, is the client willing to put up that much money for the insurance?

The product is fully underwritten. It is relatively new, so I expect we will continue to do that just because, in Canada, we're not familiar (or we don't have a lot of experience) with the risk. A lot of the experience that we're using is from the insureds in the U.K. Rather than paying a lump sum automatically upon the diagnosis, you may start to see some critical-illness products that offer a monthly payout, say for 5 years, as opposed to an automatic $100,000 all at once.