RECORD, Volume 27, No. 2*

Toronto Spring Meeting
June 20–22, 2001

Session 20PD
Critical Illness In North America—Ready To Take Off?

Track: Product Development/International

Moderator SUSAN KIMBALL
Panelists: EMILE M. ELEFTERIADIS
LAUREL PEDERSEN†
KEN SMITH‡

Summary: Critical Illness (CI) policies are designed to alleviate the financial burden caused by so-called "dread diseases. " This panel discussion addresses Critical Illness product design and marketing, focusing on the future, and includes:

- *The CI Product in the U.S. and Canada*
- *Why isn't the CI product selling at a faster rate in the U.S and Canada, and how can we move CI forward?*
- *How do we market this new innovative product?*
- *What protections do we need to build into this product and what features should we avoid?*
- *What can we learn from other countries?*
- *Current trends in product design*

MS. SUSAN KIMBALL: What we want to discuss is this new product that is ready to take off. We'll talk a little bit about marketing. Let me first introduce my speakers. I'm Susan Kimball. I work for ING Re. We develop critical illness products for our clients and we also do true reinsurance for critical illness products.

†Ms. Laurel Pedersen, not a member of the sponsoring organizations, is director of retail product development for Clarica in Waterloo, Ontario.
‡Mr. Ken Smith, not a member of the sponsoring organizations, is first vice president for critical illness & supplemental health products for Mutual of Omaha in Omaha, NE.

Note: The chart(s) referred to in the text can be found at the end of the manuscript.

Laurel Pedersen joined Clarica, which at the time was Mutual Life of Canada, in 1988. Her degree is in marketing and communications, but she started out in finance. In 1996, she was the critical illness product manager responsible for the design and launch of Clarica's critical illness product. She is currently the director of retail product development.

Emile Elefteriadis is vice president and senior pricing actuary for Swiss Re Life & Health in Canada. He is responsible for pricing all the individual lines of reinsurance for Canada and the Caribbean, and has been involved with critical illness since 1993. He also has helped develop more than 30 different products for his clients.

Ken Smith is first vice president for critical illness & supplemental health products for Mutual of Omaha. He has more than 20 years of insurance experience in both the home office and in field marketing. He was instrumental in Mutual of Omaha's entrance into critical illness and has been involved with the product design, form development, filing, and marketing of critical illness.

I'm going to start us off with just a few of the sales issues that are going on in different countries, and then Emile is going to talk about the basics of critical illness and compare critical illness in the U.S. to Canada. Ken Smith is going to discuss marketing with Mutual of Omaha, some of the things that worked well for them, and what they learned from other companies and other countries, and Laurel is going to talk about marketing with Clarica. Clarica works with career agents versus brokers, so she'll talk about that contrast as well.

Sales in the U.K.
CI sales in the United Kingdom have been going up gradually (Chart 1). I read an article recently that they have leveled off, and have maybe even gone down a little bit; but that's just a one-year change, so I'm not sure exactly how accurate that is. Critical illness policies were launched in the mid-'80s in the UK.

In 1998, they were 24 percent of individual life sales. That is obviously a huge growth over the mid-'80s. The in-force policies for critical illness in the UK totals $2.4 million, but they only have about a nine percent penetration. So they really have a lot of room for growth, whereas in the UK, it's more the mortgage market-type of product, and about 85 percent are accelerated riders.

Australia
Sales in Australia look like they're going down (Chart 2). There are five fewer companies in the 1998 survey, however, so if you look at just the companies that are in both studies in 1997 and 1998, it actually went up. There's little difference in the number of companies that reported there from 1997 to 1998. It is equal to about 20 percent of term life premiums—1998 in force was 313,000 policies, and about 67 percent were accelerated riders.

Asia

I don't have numbers here, because I got this off the survey with a graph similar to this and it didn't actually give me numbers. But these should be very representative. Chart 3 covers Hong Kong, Malaysia, and Singapore. CI was launched in 1987 in Asia and about 90 percent are accelerated riders. The interesting thing is that other countries tend to really focus on the accelerated riders, and here in the U.S., it seems like the stand-alone has received more focus.

Canada
The Canadian market is $20 million in premium, so it's really started to take off very recently. A survey came out just a few months ago that showed 63 percent growth over the prior year, so they're really taking off in Canada—but only two percent of life insurance premium. They have a lot of room for growth.

U.S.
U.S. sales estimates are from Eastbridge Consulting. On the work site market they estimate $50 to $60 million in the year 2000, and for the future their estimate is $5 billion in the next five years. However, their chaos estimate—which is done by Ken Smith—is $3 billion in 2010. Hopefully, it will exceed that.

Side Notes on Sales
In the UK, from 1992 to 1999, CI sales grew by 400 percent, and life sales actually declined by 10 percent. This is one of those great products that we like to see as a company and the producers like to see one of these new products introduced. Hopefully, that will be the way it is in the U.S.

From 1992 to 1999, life sales in the U.S. declined by 15 percent. It would be nice to have that balance with critical illness. It is growing, but it's still fairly new, and we feel that it is going to be taking off in the near future.

MR. EMILE ELEFTERIADIS: Critical Insurance is a protection product. Keep that in mind. This is a pure protection product. It's not an asset accumulation vehicle. Think more like term insurance, except instead of paying out on death, you pay out on the diagnosis of critical illness.

There are two basic plan types. One is stand–alone, and this is what I call pure critical illness. You get the illness, the contract is paid, and that's the end of that. The other one is acceleration, or advanced death benefits. This is tied in with the life insurance. When you make a payment under the critical illness contract, it reduces the amount of life insurance benefit that's available.

There's a range of illnesses that are covered. These are what I call the "core six ": cancer, heart attack, stroke, coronary artery bypass graph, kidney failure or in-stage renal disease (one in the same), and major organ transplant. The list of illnesses can be far more extensive. You can get a lot of diseases like this in other countries. In Asia, the contracts contain a multitude of impairments. In Canada, it's getting that way, but it's not quite there.
These illnesses that I'm talking about are not just mentioned, they are very specifically defined in the contract. This is an example of the current generation

artifact definition. It's got to be fairly simple so that it's understandable, but not so simple that it gets you in trouble. It's the death of a portion of a heart muscle resulting from a blockage of one or more coronary arteries. Diagnosis must be based on both new ECG changes, which support the diagnosis of a heart attack and elevation of cardiac enzymes. It's fairly simple when you talk to some brokers.

This is complicated. With something like cancer, you have a lot of terms including malignancy, uncontrolled growth, spread, and invasion of tissues. This is about as simple as it gets, and yet it's a challenge for most people to understand. That's the way it's defined in the contract, and that's the basis under which you pay claims. These definitions correspond, for the most part, with the way physicians define the disease.

Claims cost for stand-alone is basically the incidence of the disease reduced by deaths that occur during the survival period (Table 1). The survival period is the number of days that the person has to survive from the date of diagnosis. It's typically 30 days in Canada. It could be as short as zero days. It can't be any shorter than zero days.

Table 1

Basic Claims Cost

- Stand-Alone
  - i(1-qsp) where i is incidence and qsp is deaths over survival period following incidence
- 100% Acceleration with Life (approximate)
  - i +q(1-kx), where i is incidence, q is mortality rate, kx is % of deaths due to critical illness.

Swiss Re Life & Health H\ccid_tor\mad\ee\powerpnt\soaee.ppt

The acceleration basically forms the claims cost and its approximation. The logic behind that, if you think about it, makes sense. *i* is the incidence of critical illness. *q* is life insurance mortality It's reduced by some factor, and that factor is basically death as a result of the critical illness. For example, if you have a 100 percent-type acceleration contract, you're never going to have any cancer death claims because they're all covered through the incidence. You need to reduce your insurance mortality because you won't be paying any cancer claims. That's the basic concept

behind it.

I'm going compare and contrast Canadian and U.S. products. I'm going to start at a high level and then narrow it down to some of the specific product details. Generally what we find in the U.S. and Canada, is that most of the products that are selling are distributed through individual channels. Producers generate the sales. There isn't a lot sold through group, bank insurance, or Internet in either country. In the U.S., the work site is a dominant distribution channel of CI.

In Canada, there's one company that is quite successful with the bank assurance product, and that's tied with the mortgage. Your mortgage gets paid off on the first of death or critical illness. This is a great concept. To me, it's the application for critical illness.

Most of the products are individual, so most of them are fully underwritten. Some states in the U.S. will limit the kinds of questions that you can ask. Some states don't like asking family history questions or "Have you ever had ... ?" questions. They'll limit it to, "Have you ever had within the last 10 years ...?" not "Have you ever had in your lifetime ...?" You'll lose some information as a result of that.

The work site products use a simplified questionnaire of four or five questions. If you answer yes to all of those, you get issued a policy. In Canada, it's predominantly individual. The bank assurance product is a simplified product using a few questions. They're long questions, but it's a simplified issue concept as well because it's a limited face amount and it's a life, anti-selective-type sale.

In Canada, virtually everything is stand-alone. The one notable exception is the bank assurance product, which is 100 percent acceleration. In the U.S., there's a mix of stand-alone and acceleration contracts, but I think the current trend is towards more stand-alone.

The Classification

Stand-alone is considered health insurance in the U.S. Acceleration is life. This is also the case in Canada. The implication is on the regulatory front. Health insurance is a nightmare to file products in the states. That's the one big issue with stand-alones in the U.S.

The Product Chassis

In the U.S., it's a level premium, lifetime benefit type of thing. It looks like a term 100 product to Canadians. Benefits typically reduce to half after age 65. In Canada, we've got a broad variety of platforms. Most of it is term, either level term to age 75 or 10-year renewable term to age 75. When you are doing convertible products in Canada, they are very much different from the U.S. products. What happens is that for a 10-year level term, premiums level for 10 years, it renews for another level 10-year period, then it renews for another level 10-year period, and so on until it expires at age 75. There are some term-to-100 products with and without cash values, with level benefits for all the products.

Covered Illnesses
For the illnesses covered under individual contracts in the U.S., you've got the core six, plus multiple sclerosis (MS), Alzheimer's, Parkinson's (in some instances) blindness, deafness, paralysis, angioplasty, cancer—which is a popular benefit in the states, unfortunately—and bypass surgery. These benefits are limited to 10 to 25 percent of the face amount. Face amount reduces, policy still stays in force, and then when you come down with something critical, you'll get the balance.

The work sites' products are simpler due to the nature of the marketing and the nature of the underwriting. They've got fewer illnesses covered under those contracts. In Canada and the U.S., there is generally no angioplasty. Plus there are other low-incidence illnesses as well, such as benign brain tumors, motor neuron disease, or things of similar nature.

Benefit Enhancements and Riders
In Canada, virtually all the CI products have a return of premium on death, along with the CI coverage. If you die, you get your premiums back. This is supposed to make you feel better.

There's also return of premium at maturity. This is nothing but good news. If you make it to the end of your coverage and didn't claim on your CI, don't worry—you're alive, you never suffered a critical illness, and you get your money back. What a great marketing idea. That's what that is all about. In the U.S., we've got return on premium (ROP) on death, waiver of premium, and a wellness rider. Now, this wellness rider encourages you to see your doctor, so if you didn't get diagnosed, the doctor makes sure you get diagnosed and that you claim early under that critical illness policy.

Benefit Structures
In the U.S., the benefit structure is a lump sum. People have asked, "What if we make it monthly income?" Sure, you can do anything you want, but it's the lump sum people want. As for partial benefits, you'll get 10 percent to 25 percent of the face amount for the less serious illnesses. Maximum benefit, in Canada, is routinely up to $2 million Canadian. In the U.S., it rarely reaches this amount. Typically, most products have a maximum under $1 million. That's on all line, all life, total line per life, and all companies universally.

Issue age ranges typically are 18 to 65. There are some child coverages in Canada but I don't think they sell. I think one or two companies may go up to age 70 in Canada on a whole lifestyle product.

Premium Review Ability
In the U.S., all contracts generally are guaranteed renewable. You might find some with limited guarantees of two to three years. They all have a one-year guarantee. In Canada, with Canadian ingenuity and innovation, we have come up with a non-cancelable, full-guarantee critical illness product. However, the bank assurance

product is guaranteed renewal. That's a major difference between the two products. Basically, there are no rights in the U.S. other than to change premiums. This remains the same in Canada. One company does have the right to modify the definitions every 10 years, and I think that's a good idea, but it's probably too long to wait.

There's already a whole debate emerging in the U.K. about heart attacks—something that a smart pricing actuary thought we had a good handle on, and this is a pretty static event. Now they're redefining heart attacks, and now they have markers that can detect micro heart attacks. You think you have some chest pain, but nothing happens. When you go to get a blood test done you are told you have had a heart attack.

With advances in medical technology, the way things like bypass surgery are diagnosed today may not be the way things are diagnosed tomorrow. They're coming up with keyhole-type surgeries that probably qualify as bypass surgery. They've become less invasive, and it means it could be done more routinely with greater frequency. I think it's essential to have something that allows reviewability in health insurance and does it in a way that's both fair to the consumer and to the insurer.

Waiting Periods

The waiting period is a period in which no claims are paid. This is right at issue. The theory behind the waiting period is that it's for slowly manifesting types of illnesses whose symptoms are not well defined. A person can detect these illnesses within themselves, suspecting they have something. MS and cancer are two notable illnesses. Then they'll go out and buy a policy and see their doctor. There's a good news/bad news type story there.

These things are very difficult to underwrite out, so the idea was to say, "Look, if anyone gets diagnosed with cancer within 90 days, they weren't being up front on the application, because there is a question, 'Are you aware of any symptoms that you should be seeing a doctor for?'" It's hard to prove in any event.

This is meant to deal with the blatant type of anti-selection associated with cancer. The truth is that it should be for more than cancer. We've been presented with a couple of large MS claims, and we think that's what's been going on.

In the U.S., there is the same 30- to 90-day waiting period, but some states require zero days, or a limited benefit over the first 90 days. So if you get diagnosed, maybe you'll just get 10 percent of the sum insured to some maximum. Also, there's a waiting period of 30 days for the other impairments in some policies, not just on cancer, but everything that's covered will have a waiting period.

Survival Period

This applies to stand-alone only. It doesn't make sense for acceleration because you've got the life insurance and you don't need to survive any period. The period of time you need to survive from the date of diagnosis in order to claim the benefit

is primarily there to differentiate it between life insurance and critical illness. It's not death insurance. If you're going to die, you need life insurance. This isn't a replacement for life insurance.

Under acceleration, in which you have death and CI in place, you don't need a survival period because you're going to pay out the death benefit. When a person dies, he gets the death benefit. In Canada, it's typically 30 days and in the U.S., this ranges from zero to 30 days, but zero is typical. I think that primarily comes from the work site market where they want everything to be simple and don't want to give explanations on survival period and other issues.

MS. KIMBALL: We found that in the U.S., the cost isn't really that much, and this is a big deal from a marketing perspective. The marketers hate it, the consumers hate it, and it doesn't cost a lot, so it tends to be left out in the U.S. product. Most people do not have survival periods because of that.

MR. ELEFTERIADIS: In theory, it doesn't cost a lot, but I think you can get yourself in trouble.

Acceleration Percentage

In Canada and the U.S., acceleration percentage is anywhere from 25 percent to 100 percent, but most contracts offer 100 percent acceleration. Basically, the contract terminates on the first of death or critical illness. So if you die, you get your face amount and you're done. If you get a critical illness, the full face amount is paid and you're done. There are no tax ramifications.

MR. KEN SMITH: The U.S. Treasury, in its infinite wisdom, decided to come out with Susan B. Anthony dollars. They saw how well coins worked. They're supposed to last more than dollar bills do. Guess what happened? The Treasury Department never took into consideration people's perception of what this coin was, and people in the United States perceived the Susan B. Anthony dollar as a quarter. I went into my bank last Saturday morning to get some of these, and the bank only had three Susan B. Anthony dollars. The Treasury Department never dealt with people's perceptions.

What I'm going to do today is basically ask you all to throw out your perceptions about critical illness insurance. If there's one thing that you walk away from my discussion with, it will be that you see the need for this product and how this product fits together with all the other products that we're selling.

I want to start off with one question to illustrate how important CI is: If you or a family member ever has been diagnosed with cancer, heart attack, heart disease, or stroke, I'm going to ask you to stand up and remain standing. How about a relative, friend, or co-worker? Stand up. I want you to look around for a minute. We have everyone in this room standing. These are pre-conditions that touch all of our lives.

I'll provide some history, which ties in with the perception. A little more than four years ago, I inherited an old cancer product under my product management that

Mutual of Omaha had been marketing for 15 years. We started looking at the product to see if there was any potential or if we should design a new cancer product.

We came across a couple of potential companies in the U.S. that had just unsuccessfully introduced critical illness products. We saw this, started looking at it, and saw what was happening in the U.K., what happened in South Africa, and what had happened around the world. From there, we really started to do the research and saw the potential that existed for this product in the U.S.

The first time I actually saw a CI policy was when a broker that had been in Australia brought one back and showed it to me in 1994 or 1995. Like everyone else, including agents, I just passed it off. It was on a life chassis, and to me, it looked just like a terminally ill benefit. Once I started looking at this product, and once I saw what happened around the world, I started to see the potential in the U.S. for the product.

The U.K. Experience

We took a good hard look at what had happened in England before we got into the marketplace. Number one, we saw that sales were slow. It really took three to five years before the product started to take hold and take off.

There were a couple companies that basically got into the market, developed early products that failed miserably, and only sold a few policies. The initial success story in the market was Abbey Life. We looked at Abbey Life and asked ourselves, why were they successful where these other two companies had failed?

Abby Life did three things. Number one, they did the market research for the product; number two, they put together a quality product that met the insured's needs; and number three—absolutely the most important—they took the time to train their agency for it. The key ingredients for their success—and about 10 percent of their sales after six months were critical illness sales—were number one, the training. Number two, they went back and presented the product to their existing policyholders. And then number three, they had a career agency force.

The biggest thing with a career agency force is that they are more open to change. From a company's standpoint, you have much more control over the information flow to them and to their direction, and it really makes a significant difference.

We also took a look at the two companies that had initial success with the financial planners in the U.K., which are similar to the brokers in the U.S. and Canada. The first one to have success in the U.K. was Pegasus Life. The key to their success was that they trained their people that went out and called on the brokers, and trained them and trained them. Scottish Provident is another company. They made a switch. They had focused basically on pension plans, and when critical illness insurance came along, they focused on critical illness insurance, and it took them about three years for it to really take hold.

I remember talking with my counterpart at Scottish Provident. They introduced the product in 1991. In 1991 and 1992, they were running about 10 applications a week. I remember him saying to me, "The president of the company came down here asking, 'Why are we in this market, why do we want to be doing this?'" In 1999, their average monthly number of applications for critical illness was up around 3,800.

I asked them what the real keys were that made it work from the brokerage market. One is persistence—and that's what both of those companies did—and the other is a passion for the product. You really have to have a clear vision to see what this product will do.

Another point is that there's a learning curve that goes along with this product. I think that's one of the most crucial things involved with this, because you're asking agents to change what they're doing, and a lot of them are doing it very successfully. The most important thing in introducing this product is that the agent has to see the need for it very clearly, and they have to have a confidence level to be able to go out there and sell the product.

Recent Happenings

There are two exciting things that happened to me this last year with this product. Number one, when we introduced the product for a career agency system, because of rearrangements in the division offices, there were nine agents that had to sit through CI meetings twice, and it was more than a year from that first meeting until they sat through it the second time. That first year that they saw the product, those agents did not write one application; but after hearing about the product with the same words, the same presenters, the same slides, every single one of those agents wrote a CI policy after the meeting.

The other thing that's happening for me that's really kind of exciting is, at Mutual, we have new agents come into the home office after they've been in the business for about three months. The last class that came in had 14 agents in it. Twelve of the agents in that class had written CI policies. Some of them had even written more CI applications than they had life policies. This tells me that new agents coming into the business have an easier time understanding the product and the need for the product, because they're not loaded down with a lot of pre-conceived notions, like those of us who have been in the business for quite a while.

We just put together several critical success factors after talking with the people in the U.K. Number one is product design. When Mutual of Omaha went into the market in the U.S., we wanted to be an industry leader. The other thing is that in making the statement, we realized that we were going to have to go face to face with our agents. This is not a product that you can just release like a term product or even a new long-term-care product. You have to go out there and demonstrate the need for the product. The same is true with the marketing materials. We put together quality marketing materials.

Technical Support

One of the things we realized was that we did not have a lot of experience with critical illnesses. We had cancer products that we had sold successfully and managed successfully, but when it came to CI, this was something new, and we wanted to tap into people who had experience with it.

We hired a consulting actuary who had some experience pricing the product. We also took on a reinsurer as a partner, and between the consulting actuary and the reinsurer, I think we provided adequate technical support. Being on a teleconference with about 12 actuaries, for a non-actuary, is a real experience. It was one of the strangest conference calls I was ever in—there were some disagreements among all three parties.

The other factor was underwriting of claims. Underwriting for this product is totally different from any other product. Where we ended up with our underwriting worked out extremely well. We had a team of three people that did our DI underwriting that was able to grasp the underwriting and claims for critical illness probably faster than any of the other underwriting team members.

There are going to be a lot of claims that are contested during the first two years. We originally started out with the only person that could pay a critical illness claim in our company was a supervisor who had a lot of experience with major medical claims. During the last couple of months, we actually have moved it over, and we have people on our long-term care, disability income team paying claims now.

Distribution Commitment

Unless you have some sense of excitement or can create some sense of excitement within distribution, this product is not going anywhere. The last thing, is a commitment to the product. For the company to go into this marketplace, you've got to look at this as basically three to five years that you're going to have a product out, you're going to have money going out the door, and you're not going to have a lot of business coming in. If you're not willing to do that, then there's no sense in even developing a product.

Product Design

We do have an individual product, and we also developed a work site product, but I want to talk about some of the key issues that we faced from a product design standpoint.

Number one, like most of the companies in the U.S., we did a stand-alone product. From a sales standpoint, I think that's fairly key, because writing it as a rider on a life policy—particularly when you're dealing in a brokerage market—forces the broker to have to make the life sale to get the critical illness sale and it just doesn't always happen. Also, from my personal standpoint, if I was selling it, I would like having the two products because I would not want to have a life product and have my life insurance benefit cut by the amount of critical illness benefits that were paid out.

We had a difference of opinion with the cancer definition. We added the cancer

benefit to our policy, and we pay a 25 percent benefit for someone who is diagnosed with cancer. The main reason we added that was because we had agents who were very concerned that the situation could come up where women had breast cancer and we didn't pay any benefit. Given the legal environment that exists in the U.S., that scared a lot of agents away right away. It also gave the agent the confidence level to go out there and not have to worry about the definition of life-threatening cancer. It gave him or her the confidence level to go out there and say basically whether it's life-threatening cancer, this policy is going to pay for other than skin cancer. That was a big hurdle getting past that point.

The other thing and Emile and Susan have talked about has been the survival period. The first time I introduced this product conceptually to our general managers and agents, when I talked about the 30-day survival period, they just about ran me out of the room. They could not grasp that concept. It was another issue where they were worried about their errors and omissions (E&O)coverage right away.

If someone has a heart attack, dies, and all they're going to get back is the return premium, you can rationalize and justify that this product is all about survival, but when it comes time to pay the claim, the agent and the policyholder don't care about that. So we went without the 30-day survival period.

Explaining the Details

I'm going to just give a brief overview of what we do in our introductions to the agents. In the product piece, we talk a lot about the history and the background of this product. In 1983, Dr. Bernard took the product to Crusader Life. Dr. Bernard conceptualized this product because he was able to heal his patients physically, but the stress that went along with the critical illness was killing them.

Then we talk some about the need for critical illness protection. I'll give you my theory with critical illness and why the product is needed. Number one, people are living longer. Years ago this product wasn't needed because people got sick and they died. Because people are living longer, there's more opportunity for the cancer, the heart attacks, the strokes to develop.

The second thing that goes along with that, in addition to keeping people alive longer, is once they're diagnosed with a critical illness, medical science is helping them to survive more and more all the time. If you look at the five-year cancer survival rate since 1950, it has more than doubled. If you look at the one-year survival rate from strokes since 1950, that has more than tripled. But there's a price that goes along with that.

If you look at the costs involved with a critical illness, one-third of the costs are covered by medical insurance. The doctors, the hospitals, and the X-rays, are paid by the medical insurance. Two-thirds of the costs involved with critical illness are indirect costs and are not covered by medical insurance.

When I say traditional products, I mean the critical illness meets a need that's not

met by traditional products. Major medical doesn't help with those indirect expenses. Disability insurance (DI) doesn't. Life insurance doesn't either.

With the product, the other important thing is to walk away and have the agent understand covered conditions.

We put together a field reference guide that has really given our agents a big boost. It has the policy definition in it, and we also worked with our medical directors to put together some specific examples of how the conditions would be covered. The other interesting thing is that this is the only product that I've ever worked with where I've had agents say, "That's cheap. I can sell it without any problem."

Then there are life agents over here who say, "That's the most expensive product I've seen. It costs too much. I can't sell it. " One of the big issues to overcome for the life producer is understanding the difference between incidents and mortality, which leads into one of the big things we talked about in introducing the product—the underwriting.

The underwriting is different than any product the producer has worked with. Think about it. The agent has to understand that someone can be diagnosed with cancer, and that we would pay a claim on the critical illness policy. They could live for another 30 years after that before we would pay a claim on their life policy.

The other issue we have to put out there is a set of walk-away questions. These questions make the underwriting as easy as possible. They need to understand that if a person ever has had a critical illness, we're not going to underwrite them for coverage. Don't even bother to take the application. One of the things we have to understand, though, is if you come across someone who's had a critical illness, ask them about their critical illness. Have them tell you what their story was, and I guarantee agents that if you'll do that, you'll get some of the best referrals possible.

Another interesting thing that goes into the equation is that it is important to understand family history. A lot of agents are used to family histories and life coverage being used to get the preferred coverage. They have to understand that there are cases, because of the family history with critical illness, in which the policy is going to end up declined or raised. We need to explain that if someone has had colon cancer or breast cancer and they have had two or more natural relatives diagnosed with it before a certain age, they're not going to qualify for coverage.

An example I like to use, because it hits close to home with Mutual, is we had someone come in and speak to our agents a few years back. If you look at what happened, she died at age 38 or 39 because of a heart attack. But if you look at her history, her father died from a heart attack, her mother died from a heart attack, and her brother died from a heart attack.

Family history is one thing we can't do anything about. In rated cases, we end up with about 20 percent of our cases rated, and we try to make it clear and put it up front where the agents are concerned. Then one of the interesting things is, I can

deal with an agent and have him or her understand this. An agent who would have no problem at all delivering a table eight-rated life case has a difficult time delivering a table-two critical illness policy, and the issue is because it's new—the agent has never had to do it before.

Sales Considerations

There are really three areas that we focused on from a sales standpoint. The first is supplemental benefits. The second area is packaging it with disability income. The third area is moving into the advanced markets, and we are taking those steps now.

The first thing we focus on is just how it covers the indirect expense. I talked about two-thirds of those costs being indirect expenses—the rehabilitation, home health care needs, loss of income, home modification, and experimental treatment.

I'd like to point out the experimental treatment. The first claim paid in the U.S. was a woman in her late 30s diagnosed with breast cancer. There was a bone marrow transplant that could increase her chances of survival from 40 percent to 70 percent. Her medical carrier said, "No, we're not going to pay for it." She was able to take the money from a critical illness policy, use it to pay for the bone marrow transplant, and then, after going through a long appeals process, finally collect from the major medical carrier. But it enabled her to have that bone marrow transplant without a lot of the stress that would have been involved otherwise.

The second area we had to progress to was the package with disability income. With small business owners and the self-employed, the biggest issue was underwriting those people for disability income.

The income benefit amounts are based on their taxable income. Think about it. Any small business owner, any self-employed person, is going to do everything possible he or she can to keep their taxable income down. They're basically living out of the businesses in most cases. That person never can get enough disability to cover his or her needs. Critical illness coverage with the disability income policy helps get them where they need to be as far as protection.

For doctors, I think this is real clear-cut. A couple years ago a doctor in the U.S. could buy $20,000 a month in DI benefits. Based on what's happened, the most they can buy right now is $10,000 in monthly benefits.

There are a lot of doctors out there who have their income needs inadequately met. I came across a situation like that a couple weeks ago. A doctor has $10,000 a month in disability income. He had an alimony and child support agreement in which he had to pay $100,000 a year. He had a stroke. So he's got $100,000 a year, he has a stroke, and he's got $10,000 a month coming in. That means he's got $20,000 to live on. Now, he can go back to court and get alimony and child support reduced; but for a while there, he's got a problem. Wouldn't it be nice if he had a critical illness policy covering him so that he wouldn't be in a situation where he had to go back and take a big reduction?

Corporate executives are another one. A great area where it works together with DI is that group of occupations that can't buy DI coverage or can only buy limited amounts or limited benefits of DI coverage. We've had some great success packaging with DI to firemen, policemen and those types of occupations.

Other Advanced Markets

Think about the small business owner or a small corporation. If a key person has cancer, that business owner has a real dilemma. Number one, they're going to suffer a financial loss, because that person's out of the business and they have to find a replacement for him. There's also the dilemma of how long they are going to continue to support that person. CI coverage addresses those needs. I won't go into this, but I think one of the best markets for this product is going to be buy/sell agreements. If you look at a male, age 40, the chances of that person having a critical illness by 65 are 28 percent. The chances of that same person being disabled for six months are 18 percent, and the chances of that person dying before age 65 are nine percent. Where's the biggest need?

Then last, CI insurance meets a need not met by traditional products. It meets a need that's not met by medical, by disability, or by life. We ask the agents to go through who they know and get them emotionally involved with people that they know who have had these critical illnesses and just get them thinking about what a difference an extra $25,000, $50,000 or $100,000 would have made in their lives. Then we also have a consumer video. The consumer video has four Mutual of Omaha employees on it who went through a critical illness, basically sharing their stories about what happened, what they had to deal with, and what they would have done if they had the money.

Two years later the biggest issues that we have are with the underwriting. One of the biggest negatives we get back from even being up-front with the agents is the underwriting, partly because they don't understand it.

We haven't been able to provide an underwriting manual for them like they have with their other products. They're asking for more product information, more information on the covered conditions and how they affect people's lives.

As for the sales presentation, we recommended that an insured purchase between 6 and 12 months of their income. The feedback we got said that wasn't adequate. Prospects really are looking more toward 12 to 18 months worth of income. They're asking for advanced sales market support. We are doing follow-up training.

One of the things that has been most exciting is that we've been doing conference calls for follow-up training. We had Shawn Long from Toronto do a conference call with their agents. We know that we had more than 425 agents on that conference call. With a field force of 1,800, to get 425 agents together at the same time is incredible, and that's not even counting the 50 agents from Puerto Rico who couldn't get through because of the phone lines. We've gotten real good feedback from that. This product is all about change and agents needing a change, just like we do.

CI insurance was accepted by three percent of the market in England 10 years ago. Now it's accepted by 99 percent of the market. That's from Peter Dodd from Pegasus Life. I believe that same thing is going to happen both in Canada here and in the U.S. We're seeing on a regular basis that more people are accepting critical illness and the need for it.

MS. LAUREL PEDERSEN: What I'm going to cover is very much in agreement with what Ken just shared with you—almost all in agreement. Susan suggested that I share Clarica's experience with this product in Canada with you.

How many of you know who Clarica is? We formerly were Mutual Life of Canada two years ago and we're 130 years old. We did acquire Prudential of England's Canadian operations in 1996 and MetLife's Canadian operations in 1998. That left us with a career sales force of 3,000 people across Canada, including Quebec.

We have a level commission system, which is something different from our broker studies. The idea is that we don't pay a large lump sum in the first year for the sale. What our agents receive is an income from their block of business over the length of their contract with us. That gives us very high customer retention because our agents are remunerated to keep those customers in that block of business, not to churn policies and things like that.

As a result, that gives us some advantages and some disadvantages when pricing our plans. We also have something fairly new to us, two years old, and that's our brand, "Clarity Through Dialogue". That brand is used to support our products, and our agents are encouraged to provide information to a customer to help them make a decision.

So why did a company like Clarica, then mutualized, decide to go into the CI market? It is critical illness insurance. We don't sell the illnesses, we sell the insurance, so I tend to call it critical illness insurance, CII, not just CI. We were a life insurance company primarily, and the bulk of our income was from life insurance, but really it is a cash cow. I do know there are certain modifications and innovations you can do to the product, but it's all about getting more money out of that cash cow. That concept of life insurance has been around for a long time.

As for critical illness insurance, we looked at it along with other retail health insurance products as a new way for more cross-sell opportunity. We had 800,000, 900,000 policyholders whom we wanted to sell an additional policy to. Also, with our acquisition of Prudential of England, they had a CI policy. So the sales force that joined us asked us if we would continue to offer that policy. Because it was new, they were kind of getting their heads around it, and they thought it was a good idea.

Finally, in 1996, the company had a new retail customer strategy, and we were looking at new ways to fill customers' needs, and one of those was health insurance. They were seeing the life insurance used now for estate protection. It

was being used for tax estate creation, protecting an estate from taxes, but who was going to help them? My husband said to me, "Why would I buy life insurance? Life insurance did not help my dad when he had his stroke in his 40s." I only convinced my husband to buy life insurance because I told him the taxman was going to take half of his 401(k). That's when he bought life insurance. CI insurance, he understands, is a whole different level.

Product Development

In the product development process, we did extensive market potential research, and that had to do with understanding the U.K. market, as Ken suggested. We also looked to what was happening in the U.S. markets, and the fact that long-term care was a more popular product than CI insurance and why that was.

One of the things we found in Canada was that our Medicare system, that social safety net, was very similar to that of the U.K., very similar to what was in Australia, but very different from the U.S. So that made us realize that as the social safety nets were eroding because of government debt and they were looking to chop Medicare and things like that, there were new needs coming into people's minds around self-protection and self-insurance. That's why in Canada, I think we saw critical illness insurance take a forefront over something like long-term care and some of the other products coming out of the U.S.

Prudential of England, as I mentioned, had a product, and we looked extensively at their product, as well as other products in the U.K. We actually did a pilot with the product in 1997.

I wouldn't recommend pilots. The biggest problem was that the agents, because the company wasn't fully behind it were a little bit nervous to sell this product that may or may not have been around six months from then. It was good for their egos to be invited to join the pilot, but they really didn't do a lot of sales. We did learn a little bit from pilot customers, but we really learned a lot more from doing customer focus groups. I got to sit behind the smoke-colored glass and watch the tables of people talk about critical illness insurance and the concepts.

Lessons Learned

Originally, our product design had a broader definition, which was coronary artery disease, and the definition said if you had two or more arteries of ten millimeters or bigger clogged five millimeters or more...etc. It was a very complicated definition and the customers raised their arms and said, "I don't get it, it's too complicated, I'm not interested." Even though it was a more robust coverage than just coronary artery bypass surgery coverage, which pays you 30 days after you survive your surgery, they were more inclined towards the thing they understood rather than this broader, more robust definition that they couldn't understand. We took coronary artery disease out and just made it coronary bypass. We put in MS coverage, which they all could get their heads around, and we did that for about the same price.

We discovered that we were originally going out with a term insurance product that

ended at age 75. We did not have a maturity benefit. They didn't really exist back when we were first designing our plan. So when customers and agents saw that the coverage might end at age 75 and they didn't have a critical illness and they were still alive and the plan ended and they got nothing, this caused discomfort, more for the agents than for the customers, but a little bit for the customers.

Then we introduced permanent coverage, lifetime coverage, and that was to support the conversion. We thought we were designing permanent coverage just for conversion, but we found out when we launched that about 25 percent to 30 percent of sales are actually for that permanent coverage. The reason for that is that customers see coverage for life. If I die, my estate gets the return of premium, and if I get a critical illness, I get the benefit. Therefore, the only cost of that insurance is the opportunity cost if I invested my premiums elsewhere. That's a big feature that a lot of agents are using to sell the permanent version.

Finally, we had heard from customers that they were skeptical about definitions. They were worried that what if they got something that didn't meet the definition, the whole cancer situation, that we were not going to pay. We looked at including a functional disability rider or coverage illness.

If you're familiar with the activities of daily living (ADL) definitions in a long-term care plan, what we said was this: "Regardless of cause, if you lose two of these ADLs, we will pay the benefit." We thought that was an exceptional idea. Our reinsurers were quite excited at the time, but our corporate executives were not ready to go there. We had to take that one out, and that's the biggest "I told you so" of my life.

Marketing Strategy

We also took our marketing materials before our consumers. We did two rounds of consumer testing. One was about product concept, and the second was about our materials. We had a brochure, a sales presentation, and a pre-approach letter, and all were customer- and producer-tested.

These are some of the things that we learned: Do not compare this product to life insurance. We went out and said, "It works just like your life insurance policy." Well, people don't know how their life insurance policy works, so you really had to go back to square one and explain, because they honestly believed even with life insurance, 10 years into it, they were going to have to reapply with new evidence to get renewal premiums, and so we had to go back and explain it to them step by step.

A lot of customers said, "This product is too good to be true," so we probed with that and asked, "What is it that would make it not too good to be true?" or "What is it that you want to hear to trust that we really will be there for you and pay?" The big answer was as long as it was offered by a recognized provider. That's why so many sales initially come out of your existing block of business, going back to your existing customers, because they dealt with you already, they have a confidence in your company, or at the very least in the sales representative that they've dealt

with. Therefore, they start to trust the company that's offering it.

Sales Strategy
This is one of the things we taught agents. Even though it's a new and exciting and fun concept, and they want to talk to all these new prospects about it, prospects aren't where you're going to get your sales. Where they're going to come from is your block of business.

The other thing that people needed to see was how to spend the benefit. They really couldn't get their head around, "The money really is mine to spend, you're not going to assess my claim, I don't have to send you the cost of my wheelchair and you'll reimburse me." The concept of the lump sum and being in control, and then the "A-ha." As soon as they saw how much control they had over this sum of money, they saw that was one of the huge benefits in the plan is it really does enable me at a time in my life when everything's falling apart.

At Clarica we had a unique experience. I was product manager at the time, and I was given these three inceptions. No national product training road show, no national advertising campaign, and no recognition credit. How would you like to launch a product in that environment?

As a result, we had kind of moderate initial sales. Go figure. Surprisingly, though, we had some sales, and you kind of wonder, "How could we possibly get any sales?" I'm going to teach you a little bit of Marketing 101. That's about adoption patterns. This can be applied to consumers, but it can also be applied to your sales force. Most innovators, the 2.5 percent of the sales force, said, "Wow, new idea, something fresh, fresh meat, something to get my head around, something new to talk about." They adopted it and started selling it, and that's where those initial sales came from. We move along the pattern, and you get that first little red strip, 2.5 percent of your sales force selling it. What do you have to do to get the rest of them? You have to find those innovators, and you have to reward their behavior. A lot of these innovators, all they need is a medal of honor, and with these guys we gave them watches, and they were able to go around the branch going, "I got this watch, and you didn't get one," and we gave them a watch for their first sale to somebody other than themselves.

It was very important, and we found this out in hindsight. If you have your branch manager, your sales management "on-side," then that opens up core opportunities to you.

I could point to those branches across the country where the managers were actively involved in promoting the product versus those that weren't, and it made a tremendous difference. Remuneration and recognition is key. The reason they didn't let me remunerate and recognize very much in the beginning is they were really worried about cannibalization, that agents would switch track and sell critical illness insurance instead of life insurance. We had to prove to them using sales results that it was actually enhancing both and that there was not cannibalization, and then they agreed to remunerate.

As soon as this started to count as life insurance toward their goals and things, sales took off. Of course, those innovators usually are recognized by their peers as innovators, and you can get great success stories, because no matter how big your brainchild is from the puzzled palace of head office, no agent is going to listen to it. They've got to hear it from one of their own.

We wanted to get into the new early adopters. We wanted to get into those early majorities. What did we have to do to get more people selling this product? Here we are, four or five years later and we are still only seeing about a third of our sales force selling the product actively. And of that, maybe 10 percent are selling more than one a month. So this isn't an adoption pattern that is slow, but this is what you can do to help it along.

You have to recognize that these guys, other than innovators, are in their comfort zones. They are old dogs, and they don't like new tricks. They're no longer the experts when they're talking about critical illness insurance. They're not comfortable describing cancer to someone, especially when the best example is cancer of the cervix.

There are people actually making these purchases for totally unselfish reasons. For example, I'm a mother of two, and if I get cancer, I don't want my children's lives impacted by it. I'm buying it for my kids, not me. When I get cancer and I get my money, my kids are still going to get to ball practice and are still going to have new bicycles and are still going to have a roof over their heads.

It is a different need, and as I mentioned earlier, we had traveled down that life insurance road where life insurance is now a very practical sale, it's about estate creation, it's about estate protection from taxation, where agents had to be comfortable going back to selling that emotional need, family protection, and "What–if " questions.

Emile mentioned that we had a change in definition 10 years down the road. Not a good idea. As much as the reinsurers like it, and as much as some of the more conservative actuaries in our company thought it was great, the consumers said, "No way," and we had a big struggle explaining that clause was as much to their benefit as to our benefit, and they really didn't see that benefit. It's not there anymore, mostly because our other reinsurer wouldn't give us a price break. We asked, "Is there an advantage to keeping this in the contract? Can we charge our customers less?" They said, "No," and we said, "Fine" and took it out.

Finally, in closing, is how to encourage producer adoptions. Take advantage of those innovators, pull them in, market to them. Remember, though, that there is that adoption pattern. It's not just a learning curve, as Ken mentioned. It's also opening their minds to being receptive to the learning. So you have to change your programs along the way to identify that. First off, I'm dealing with the guys that want new and different and exciting. Later on, I have to start dealing with the guys who are a little bit more cautious and who want good, practical reasons to sell the product.

Now we will discuss rewarding positive behavior. Ken mentioned how he used Shawn Long. Our company used Shawn Long as well. I tracked sales results quite closely after his meetings across the country, and one of the things that we found was that while there were agents who started to sell this product who never sold it before, where we really got the impact was more sales from the guys that already were selling it. I think what Shawn did for those people was to say first of all, the company is paying money to bring this guy out to us, so they must really believe in this product. Secondly, it was, "I am on the right track, I am doing the right things, it's been painful, and I have to learn new stuff, but it's worth it and I'm already seeing the benefits. And Shawn just proves to me that I'm going to reap more benefits from it." You have to share those successful sales and marketing ideas and in any way, shape, or form that you can think of. A lot of people looked at Shawn Long, and it was just a really fun day, and that was just as important to energize as it was to really see real, true sales concepts out of that.

Educate to reduce discomfort. That entails things like explaining what cancer is, helping with plain language, contracts, and user-friendly explanations of the illnesses so an agent can feel comfortable sitting down with his or her customers and learning the product together.

Finally, acknowledge that there will be laggards and you may never get some of your agents selling this product. At Clarica we have 3,000 agents, and if I can get one-third of those who have been in the business for five years or longer selling this product on a regular basis, I'm successful. And if I can get 100 percent of the brand new guys coming in who see the whole picture, and understand that it's not a new addition to the financial services that we offer, it's part of the whole package, then we believe we can get 100 percent of the new guys to sell it as well.

MS. KIMBALL: This is the global prospective of critical illness in other countries. A lot of people have heard about U.K., Australia, and Asia. And Canada, even though it's under slow, stable growth, is really starting to take off, so that should move to another section fairly soon. The U.S. is fairly minimal, but we see that growing in the very near future.

Illnesses covered are likely to increase. In the U.K., there are up to 30 different illnesses covered. We like to keep that much simpler, especially in the work site market.

For claims, you have to have underwriters who are well-trained. You really need to look at anti-selection in your claims experience. Anti-selection appears all the time. We need to think about waiting periods to help with anti-selection definitions, those kinds of things. Medical advances could cause earlier detection, and one of the things in the U.K. is that they tend to cover coronary artery bypass operations at 100 percent, because they introduced this in the mid '80s when it was very low.

In the U.K., this is becoming more common too, so you have to think about that in pricing and that these kinds of things could change in the future. Some of that's hard to know, but we need to have that little bit of extra cushion or insight for these

kind of things happening.

Chart 1

CI Sales in the United Kingdom

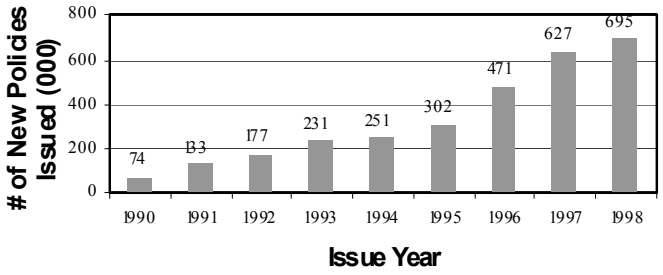

Chart 2

CI Sales in Australia

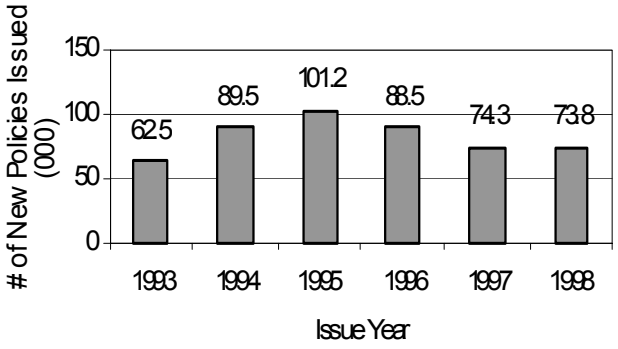

Chart 3

CI Sales in Asia