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Overview of Critical Illness Insurance

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Summary: Panel members provide an overview of current practices and breaking trends in the critical illness market. Topics for discussion include benefit design, pricing considerations, recent experience and long-term outlook for the product. Attendees gain a better understanding of the underlying concerns and the future potential of this relatively new product.

MR. MICHAEL L. RASMUSSEN: I'd like to give a brief overview of what critical illness insurance is. I'll take a couple of moments and go over why anyone would actually want to buy a critical illness policy, and we'll close with a quick look where some of the markets are.

Critical Illness Policy Defined

What is critical illness? Critical illness insurance is a very simple product. Normally, you have a lump sum cash payment that's paid upon the occurrence or diagnosis of one of a number of specified diseases or conditions.

Typically, there are five conditions that are covered. I like to refer to these as the Big Five. The first three of these—heart attack, cancer, and stroke are generally always in a critical illness policy. The latter two, kidney failure and major organ transplant, are almost always there.

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In addition to the Big Five, there are a number of other conditions that are commonly covered in a critical illness policy. Of these, bypass and angioplasty are probably the most frequent ones. They, however, normally are covered at only about a 25 percent benefit level. Of the other ones that are covered at the 100 percent level, paralysis, blindness and multiple sclerosis are probably the most popular. Other conditions include Alzheimer's disease, deafness, loss of limbs, and HIV under restricted conditions.

Typically, you can see between five and 15 different conditions covered in a policy. The average is probably around nine to ten.

Types of Policies

I'd like to go over a couple of different types of critical illness policies. One is the stand-alone policy, and the other one would be an acceleration of benefits policy—it's usually as a rider.

Stand-alone. The stand-alone policies pay the lump sum from the diagnosis of a critical illness, after a survival period of, say, 30 days. Once the policy has paid its benefit, it terminates.

The survival period clause was very common when critical illness policies first appeared. The more recent trend has been for the elimination of this survival period. The survival period is the time after insured actually had the heart attack. The insured has to live 30 days before he or she could get the payment.

Accelerated Benefit. The other main type is the accelerated benefit plan, or the accelerated rider. Here, it's usually a rider attached to a life insurance policy; and once you have the condition, it pays some percentage of the face amount. The remaining face is paid upon death. The major element here is the triggering event. Here, you don't necessarily have to be dying; you just have to have experienced the critical condition.

Variations. There are a number of benefit variations and riders available or possible.

Buy-back Rider. One would be a buy-back rider. This is a reinstatement in benefits rider that, after a critical condition has occurred, you would come back and try to buy back some of your coverage after a couple of years.

Reduced Benefit Period. Currently the benefit pattern is typically a level benefit for life. The major variation would be the reduced benefit amount at age 65 or 70. Some policies actually have it after the policy has been in force for a number of years.

The big advantage of something like this is that it keeps the premiums at a more reasonable level.

Face Amount Fraction Payment. Another benefit variation is that some benefits are paid at 25 percent of the face amount. This is like coronary bypass or angioplasty.

Common Provisions
One of the more common policy provisions was, as we discussed earlier, the survival period. At one point this was very common; now, it's less common. People are shying away from that.

There can also be a waiting period. Here you have to have the policy in force for a certain period of time before the condition strikes you, before you'd be covered. That again, was more common in earlier policies. It's less common today.

Definition of Critical Illness
The scope of the definition is very important. You have to be careful, or else you'll open it up to many more conditions than you originally anticipated when you priced it.

Underwriting
The underwriting for a critical illness seems to run the gamut from fully underwritten to guaranteed issue, with simplified issue being probably the most common.

Some of the facts that you'd like to take into consideration would be prior history, family history, and number of risk factors.

A brief note here on some of the claims administration aspects of critical illness. It seems to be easier than disability, and a little more difficult than life insurance.

Regulation
Critical illness insurance is regulated by a number of states. There again, the gatekeeper provisions seem to have been troublesome, and that's probably one reason why the survival period and the waiting period have lost favor in a number of products.

Why Buy a Policy?
Why would anybody want to buy a critical illness policy? Well, the events are very real. Chances of having one of the major five are very high compared to death; and more importantly, I think most people out there understand that something like that could happen to them.

Along with being life threatening, there is a lot of economic insecurity that goes along with having a critical illness—loss of income being one of the more important.

So with that said, there seems to be a lot of potential uses for the critical illness benefits—everything from medical expenses not covered by insurance to mortgage payoff or even a final vacation for the insured.

The appeal for critical illness is that it's not expense reimbursement. It's not based on your inability to work or your impending death. It's a living benefit that is payable to you.

Critical illness has been around for a number of years. It started out in South Africa in the early to mid-1980s, and it's been fairly popular in the UK, Australia and Japan since the 1980s and early 1990s. There have been a number of U.S. attempts to start critical illness insurance. They haven't been overly successful in the past.

Why is it making a comeback in the United States? I think with the aging baby boomers, everybody is looking for products to target to them. I think people perceive this product as being attractive to the middle ages and the near seniors.

Another advantage of critical illness is that it's a fairly straightforward product to describe and understand by the insured.

Critical illness may be attractive in several different markets, from direct response, work site, individual sales, and in the group market, as well.

MS. LORETTA J. JACOBS: I'm going to tell you a little bit about pricing critical illness. I'm going to repeat a couple of things that you just heard, but more for you to get it solidified in your head.

Critical illness is a lump-sum benefit. It's not expense reimbursement; it's not a hospital indemnity policy, if you will. It's a big chunk of money that you get after you've been diagnosed with one of these disorders.

As Mike said, the ones on the left are the ones you typically see in your policy (Table 1). Then there are always different variations, and companies are always looking at different combinations of disorders that they think might be interesting to cover. So you'll see other versions out there.

At least so far, anyway, all the products have been designed to be a level premium from either issue age or issue age band—maybe five-year age bands are used.

Table 1

Product Design

Benefit of $10K – $50K Lump Sum on First Diagnosis of "Critical" Illness, such as:

- Cancer, other than skin cancer
- Heart Attack
- Stroke
- Paralysis
- Organ Transplant
- Renal Failure
- Multiple Sclerosis
- Coma
- Blindness
- Alzheimer's Disease
- Other "Terminal" Illness

Short-form Underwriting
Generally speaking, for stand-alone policies, you're looking at short-form underwriting. You know about the anti-selection of people who have family history of certain disorders. Short-form underwriting is not going to catch all that; so you have to have some additional risk control features in your policy, and they vary from company to company.

Pre-existing Conditions. I think everyone is familiar with what pre-existing condition exclusions are. If you've had treatment for something before you bought your policy, within a certain period before you bought your policy, you wouldn't get paid for having a claim right after your policy was issued for that condition.

Graded Benefits. A graded benefit provision is a similar idea. Within a certain period of time after the policy has been issued—and usually it's two years—any critical illness claim will only pay a certain percentage of the face amount. After that period is over, then if you have a critical illness claim, you'd get the full benefit that is the face amount of your policy.

Attained Age Benefit Reduction. The attained age benefit reduction kicks in and after you reach a certain age—65, 70, or 75 are typical ages—the benefits summarily reduce in half.

Survivorship Waiting Periods. As Mike said, the survivorship waiting periods have really fallen out of favor, but they are still there, and you will still see them. They can range anywhere from 14 to 30 days. So you might have a heart attack,

and you're expected to live 14-30 days before you get paid your benefit. If you don't survive that period, you don't get anything. So you can see why regulators aren't really too keen on that provision.

Worksite, Direct Response Success
The most success — and I wouldn't characterize critical illness as having been real successful yet—that we've seen has been with work site and direct response distribution channels.

Pricing the Policies
Clearly, as pricing actuaries, we're going to worry the most about morbidity.

Where are you going to get your data? You can find data on the Internet. The American Cancer Society and The American Heart Association do great work, and they have lots of good stuff on there. The Center for Disease Control and many government sources can give you lots of data.

You do have to be really careful though because it is population data. You don't necessarily know how to interpret it. A lot of times studies have been done in a way specifically for the medical research aspect of what was being studied. So you have to be careful to interpret results compared to what you're trying to do.

For example, if you're attempting to price an insured policy; you have to think about how the insured environment differs from the population study or whatever it is that the either government or a society of some sort was doing.

You can also get information from consultants and reinsurers. They keep a lot of proprietary data that you'd have access to. Of course, if you're in the health insurance business, you may be able to use your own experience.

You have to remember that we're talking about really low-incidence, high-severity claims—organ transplants, for instance. I mean, even if you're a big health insurer, it's not clear how much data you would have on how many people got a kidney transplant. You can definitely make some conclusions about the relative relationships of claims; but you have to remember that this is not necessarily highly credible information.

Particularly, when you're looking at how to translate population data into what you're going to use for pricing, you definitely want to consider the anti-selection aspects, and what risk control features you are using in your policy.

Durational Impacts of Underwriting
What are the durational impacts of underwriting and these pre-existing clauses, graded benefit clauses and attained age benefit reductions? Some things are more effective than others.

There are downsides to doing almost any of these things, even outside of how they might be viewed in the market or by a regulator.

Distribution Issues
There are also distribution channel issues. The morbidity that you would experience from direct response is probably not going to be the same morbidity you're going to experience with worksite, true group, true agent marketing, or broker markets. They're going to be different. You have to remember that and to think about how the distribution method would impact your pricing.

Other Key Issues
What are some other important issues?

Critical illness, especially a product that doesn't reduce the benefits at age 65 or 70, has a pretty steep claim cost curve.

You've got level premiums, so you're going to be building fairly large active life reserves, policy reserves. Of course, that means a couple of things. You have to pay some attention to how you're investing your reserve asset, the assets backing your reserves. That investment income assumption will be important.

Then you'll have the issue that, if you have low lapse or low mortality rates. You've got more people attaining those ages where claims are really going to start to climb, you have to have the right claim cost out there. But, if you're expecting fewer people to last to that point, and then you get a lot more people out there, lower lapses can have a negative impact on your profitability.

So it's a little bit similar in that respect to long-term care. But it's not something that is intuitive to most people. They think low lapse rates, that's good! It's difficult to admit it's bad news that people liked your product so much, that they stayed on board. It's just one of those things though that you got to think about: What's going to happen now, if you've got a lot of people aged 80 insured that you weren't expecting to have? Are you sure you have the claims out there correct?

For the other assumptions and expenses, there's not much real interest. I don't want to spend a lot of time on those. But I thought what might be interesting is to go through a little bit of a sensitivity analysis with you to show you how some of these assumptions interact and what can happen actually for our pricing.

Illustrating the Point
This is all illustrative. Let's assume that we have a basic critical illness (CI) policy. You're covering heart attack, cancer, stroke, renal failure, and organ transplant. You're at age 47 at issue, which is one of the target ages in the band. You've got a $25,000 lump sum benefit available to you.

We're going to look at this in two different distribution channels. One is in direct

response, and one is going to be in the worksite approach.

If we're doing direct response, and we're doing a mail program—we're going to create a bunch of brochures, mail them out to people who we think are in the target band—and then they'll reply back and say that they want the policy, and that's how they get insured.

So my acquisition cost is a fixed amount. It's related to how much it costs me to produce the brochures and mail them to people. If I get nobody to reply back to me, I still have the same cost as if I get everybody to reply back. So it's a fixed cost.

We're going to assume we've got some fairly high lapse rates in the first year, grading down to an ultimate level after four years. So it's grading down. It's not a level lapse rate.

We have this profit goal that we'd like to meet of five percent of premium. It's a post-tax and target surplus goal of five percent. We're hoping to get about a 55 percent loss ratio, which is pretty standard.

Well, let's look what happens in several scenarios. Impact on profit would be the difference of going from 5 percent to plus 0.8 (Table 2), that's going to 5.8 percent. Same thing on the loss ratios: If I'm starting with 55 percent, and I say I go up four percent, I'm going to 59 percent.

Table 2

Illustrative Sensitivity Testing, Continued

Assumption Chg	Impact on Profit	Impact on Loss Ratio	Impact on Acq. Exp Ratio
Interest Up 1%	+0.8%	none	none
Interest Down 1%	-0.8%	none	none
Level Lapses	+6.5%	+4.0%	-14.7%
Lower Level Lapses	+5.2%	+12.0%	-18.7%
Higher First Yr Lapse	-5.1%	-1.1%	+9.4%
10% Higher Claims	-3.1%	+5.3%	none
10% Lower Claims	+3.1%	-5.4%	none
Enrollment Up 33%	+4.9%	none	-7.9%
Enrollment Down 33%	-9.7%	none	+15.9%

Acquisition expense ratio is your total cost for acquisitions and dividing it by the lifetime premium stream. If it was 30 percent, and it said add 15 percent to it, then it would be 45 percent.

If we look in the direct response market, although I just told you that investment is important, for a direct response, it's not terribly important. My big issue with direct response is how to get the enrollment up and how to keep people on the books.

In direct mail, you don't have big numbers to begin with. So, if you're talking 0.15 percent responding, and it goes down to 0.1 percent, that's a third drop, but it seems like it's all around the same range. But all of a sudden your profit really tanks! Remember, we only had a 5 percent profit goal in the first place; so to have it go down minus 9.7 percent, you're losing money!

That's not because the loss ratios went up; the people are assumed to behave the same way, but you had fewer people enrolled. You had that fixed acquisition cost, and you're dividing it over fewer people and less total premiums.

The opposite occurs, if the enrollment is higher than you thought, if it goes from 0.15 percent to 0.2 percent, but you wouldn't necessarily say that that's so much better than I thought. In fact, it has a huge impact, because when you're talking small numbers, any increase is a big increase. You're reducing your acquisition expense ratio.

Your claims are fairly predictable. If you're 10 percent off, either better or worse, and you had a 55 percent loss ratio, the plus 5.3 and the minus 5.4 are about 10 percent of 55 percent loss ratio. So that's going to have a pretty standard, predictable relation to your profitability.

Lapses. It is very interesting what's going on with the lapses. I said this was a four-year drop in the lapse rate to its ultimate level. So let's assume for the moment, that instead of getting something grading down to that ultimate level after four years, you got the ultimate level in year one, and it stayed that way. It was a level lapse. Your profits went way, way up!

That's good. Of course, you're thrilled. Now, let's assume that you have level lapses again, but they're lower than the initial level that you thought. Instead of 15 percent to make up a number, they're 10 percent.

Well you're still much better profit-wise than you originally planned in your pricing, but it's not quite as favorable.

You see that difference? It's plus 6.5 versus plus 5.2, and that's happening because you're getting more people out at those higher attained ages, where the claims are really going up. Your loss ratio is going to go way up. Even though you have more premium in from these people, because you had lower lapses, that only has so much of an impact at some point on your acquisition expense ratio. It's not quite as favorable. It's still a good thing. You're still happy, but you're not quite as happy.

What would you expect if you have a high first year lapse—a really high first year lapse, higher than you planned? You're going to have that much more trouble recovering your acquisition expenses, and that impact is going to outweigh the reduction that you're going to get from not having people out at attained age 80.

If we look at this more like an agent based marketing in the work site, we're going to switch from a fixed acquisition cost to a variable cost acquisition-expense relationship. We're going to have a heaped first year commission and then a renewal after that.

You are using payroll deductions; so you're assuming, just for the sake of argument, that you're going to have level lapses. You've still got around the same profit goals—5 percent, but, because you're in the worksite, you think you should be really competitive. You want to have a higher loss ratio. So you're going to be better, more expense–efficient.

Considering that you're only paying acquisition expenses on anyone who enrolls, and you don't pay anything if you have no one enroll, it doesn't matter whether your enrollment is high or low. That's totally nonentity in this equation.

The interest rate being higher or lower looks a little bit more important and is

something to not be forgotten about. In the prior example, you had so many other issues that were more important than interest, you probably never got a chance to really think about it. Here now you really want to think about it a little bit.
The claims are on the same issue. We start with the higher loss ratios, so if claims are 10 percent higher than we planned, you're going to have a slightly bigger impact on profit than in the prior example, because we started with a higher claims assumption.

But again, look what's going on with the lapses. Now, instead of planning for 10 percent level lapses, maybe they went down to 5 percent. The profits went down, even though you're telling management that we did such a great job in administration and we kept everyone on. Your profits went down. You didn't do such a great job.

With higher level lapses, if they went from 10 percent to 15 percent, now your profits went up and so, people are shaking their heads again, saying that we should purposely try not to keep people on. It's just one of those things that happens.

Like the other example you're going to see, obviously you have high first-year lapses—again, because you had that heaped first-year commission. This maybe wouldn't be so true if it was levelized commissions, but we have heaped first-year commissions. So if we have higher lapses in the first year, you're not going to be able to recover some of that commission stream that you had.

The big thing to note is that the relationship of what's important on your pricing has changed from distribution channel to distribution channel and why you'd want to think about that overall when you're pricing.

MR. JEAN-MARC FIX: As I was listening to these presentations, critical illness is really a new realm of benefits. All of your old thinking about existing products that you're familiar with has to be put in question again. We'll cover how that is affected by the design of the policy itself and the policy benefits.

I'll cover first, very briefly, some things we've covered several times so far—the policy benefits. Then I'll go over the selection criteria for the triggers. By triggers, I mean the critical illnesses or events that trigger a payout. Then I'll cover some issues with definitions in general, and then go over some practical examples.

Simple Concept
As we said, it's a simple concept: A lump sum is paid on a trigger. Now, the lump sum is not always the same lump sum depending on a trigger, and that's one of the control mechanisms that you have to control your cost issues and your policy.

The benefits are not a reimbursement, and that makes this product very attractive to the policyholder. It's really a payout that has no strings attached. As long as you meet the definition of the payout, we will give you money. You can do absolutely

whatever you want with that money.

A common use for that money is experimental treatment, or going to a better cancer center, like, let's say, the Anderson Center in Houston, with all the additional expenses that something like this will entail. So you see, there are a lot of potential uses for that money.

When you go over the list—and, to a great extent, the competition has decided pretty much what that list is for you—you're always balancing the perceived value of the benefit with the actual value. You'll notice very quickly, especially if you deal with your marketing people, that there is quite a difference between what the policyholder or your agent thinks is important and what you think is costly. Cancer and organ transplants are two examples of this: They both have high-perceived value, but they have very different costs. Organ transplant is almost an incidental cost compared to cancer. Cancer is, by far, the major cause of claims in all critical illness products.

Some items will add a lot of cost to your product, and you might want to think very carefully before including them.

We discussed angioplasty, and the answer to that is a lower pay out benefit to try to manage this cost. In the situation of cancer is also something that is extremely attractive to the applicant and the policyholder who has serious cost implications. We'll go over those two examples in more detail a bit later.

Anti-selection was a very important consideration in the design. For those of you who are from a life insurance background, life insurance already is subject to anti-selection, and a significant amount of it.

In critical illness, the person doesn't have to die. The person who buys the policy gets the money. That really multiplies the potential for the reward for the anti-selection.

Second, a lot of the diseases that are covered by a trigger, especially cancer, are not well identified in the traditional underwriting framework. Family history is an important factor, but it's not the only factor. So there is some potential impact of anti—selection on your incidence rate. That is the most important factor to consider between the population rates that you'll get and the insured rates that you'll need to project.

Issues With Definitions
The definitions have a dual, and kind of a contradictory, role.

They need to be simple for the applicant. The agent needs to know what he's selling or she's selling, and the applicant needs to understand what they're buying; so use simple language.

But the need to be complex is very real. When your claims department looks at a claim, they need to be exactly clear that it's covered or not. In a life insurance policy, it is clear, the person is dead or alive. If the person is on a health policy, they had an expense incurred, you have a bill—that is clear.

This is not the case in critical illness. From our own personal experience, a significant number of claims, or attempts to claim, don't make it to a claim payout. There is a lot of not necessarily misunderstanding, but not meeting the definitions. It is really important to have an unambiguous definition as much as you can, so that you are not exposed to needless claims.

Cancer Claims. For example, in our own experience with cancer claims, half of the people with cancer's first attempt at claiming do not come up with a claim pay-out. For a number of them, it is because when we send the proof of claims request there is nothing to send back. In a couple cases , the person had cancer before they bought the policy, and that comes up in the claim. As agents get more savvy, and the applicant gets more savvy, you might get them just afterwards. So you have to be very careful for that.

Three Key Questions
So of the three questions you'll need to answer the first is "what is covered?". Cancer, heart attack, and stroke are almost mandatory nowadays. There are several other important ticket items that may or may not be covered.
The second question is "who verifies the trigger event?" I'll cover that briefly.

Finally, a real key question is "how critical is critical?" I think there has been an evolution of the product from critical "life–threatening" to critical "I don't feel too good." The simple definition is that, as I said, the applicant needs to understand what is covered, and the agent needs to understand what is sold and answer questions correctly.

Agent brochures are critical for any kind of agent-mediated sales. The quality of your direct marketing package is critical. There are a lot of statistics that you can find to put the benefits in perspective. Be careful about the value of the statistics that you use, though.

The definition also must be unambiguous—and we're talking a lot of time about complex, technical, medical events that often are the result of chronic disease for which the starting point is not always clear. Cancer is a good example of that. You have a substantial claims verification process that is a lot more cumbersome than a life process; and it's probably akin to long term care claims process, as far as verification, at least the first time.

To add to that process, the definitions are not originated by the company. They really are based on the medical literature and the medical research; and therefore, they evolve with needs that are not parallel to the needs of the insurance company

to get them stable. That is a critical issue, and I'll have an example of that a bit later.

What is Covered?
You have at least two tiers of coverage. There is a fair bit of variety in the second-tier list of diseases. There's been a lot of one-upmanship. People will say they have a new disease that you don't have to make your policy a little bit harder to compare to somebody else's rates. That, of course, has an impact on the rates, which can vary from a high impact, such as your cancer definition, to a fairly moderate impact, such as your organ transplants.

Who Certifies Trigger?
Who certifies that the trigger is met? I think you need to be clear, as well. It has to be a medical doctor, licensed to practice in the U.S. You need objective and recognized criteria.

The "objective and recognized" sometimes creates problems, as far as the medical definition that is dependent on pain as a trigger. We don't have any way to measure pain, and that is unfortunate. It makes it very difficult when the clinical definition involves pain as one of the trigger factors and you have to eliminate that from your policy.

There are a few questions that come up when people mention critical illness. I think, the first question was what "critical" meant. Is it a lethal disease that will degenerate to death very quickly if no treatment is given?

Then we evolved to a second-tier definition: Is the treatment cumbersome? When I say "cumbersome," I really mean invasive and unpleasant. Is it objectively and practically measurable? That's a question that you need to ask yourself when you define that trigger.

Is the treatment recognized by the public? The flip side of that—is it affordable? Obviously, the more recognizable and the least costly, that's the best combination. On the other hand, you want to provide a product that adds significant value to your policyholders' insurance portfolio, and you need to cover at least a significant amount of their critical illness need. Otherwise, you'll have a bunch of unhappy people.

Critical Diagnoses
I'll cover a few examples of some of the issues that you have to answer when you design and select those triggers.

In Situ Cancers. In situ cancer is probably the first one. Most policies do not cover in situ cancers, because of the definitional problems. Generally, in situ cancers are very survivable, especially prostate and breast. But, the treatment is often expensive and traumatic for the policyholder—as an example, carcinoma in situ of

the breast that is treated pretty much the same way as a bigger or deeper cancer of that same area.

It increases the cost significantly for men over 60, because of prostate cancer, and women in their 30s to 50s because of breast cancer. It has a significant cost impact, especially for the woman at the prime buying age of your insurance population.

The concern with in situ cancer is when does the disease start? The answer is, the disease starts at soon as you can recognize it. That changes with technology. There is a theory that in each of us there are a few cancer cells, and that our inability to recognize those cancer cells is what prevents us from being diagnosed with in situ cancers.

The question is, how far down in the number of cancerous cells do you need to go before you can recognize them, and how much diagnostic advancement will foster an earlier and earlier detection of cancer, and probably a greater increase of cancer that would probably have remained undetected for an extended period of time?

Angioplasty. Angioplasty is increasingly used in lieu of bypass. The utilization rates of bypass surgery are fairly established. Angioplasty picked up very fast and has now, I think, increased higher than bypass as far as use. It's very common, it is minimally invasive, and has very little risk nowadays to most policy applicants or policyholders.

The question here is, can angioplasty be used as the trigger to pay out the policy? Are there sufficient dollars paid out on an angioplasty that it's worth it for the person to complain to his doctor of chest pain and —after some testing of minimal plaque—have an angioplasty done anyway?

As you add new, more minimally invasive procedures, the anti-selection increases, because the possibility of triggering that just for the pay out, if it's a really high face amount policy, is very real.

The answer to that concern, though, is the lower pay out that you see in most policies. It controls the cost, and it makes the cost, versus the trouble of bypassing just to get the money, a lot less interesting.

Multiple Sclerosis. Multiple sclerosis coverage is popular, especially in Canada. It's a low-incidence disease in the general population. It has good name recognition in northern countries such as England and Canada, maybe more than in the U.S. Claims here are 10 times, or thereabouts, the expected population incidence rates—5 percent to 8 percent more claims. That's a significant chunk of your profit down the drain. So it is really important to assess the impact of anti-selection properly, especially on diseases such as multiple sclerosis, where the person could have symptoms for many years without seeing a doctor, and it takes many more years

before the disease is diagnosed.

Breast Cancer. Another example would be a lump in your breast or chest pain for a while. There are a number of chronic conditions for which the person will be hesitant to see the doctor for quite some time but might be suspicious of a critical illness and therefore more prone to buy your product.

Prostate Cancer. With prostate cancer, the old definition excluded Stage A prostate cancer.

Stage A prostate cancer was a cancer that was found incidentally on removal of the prostate, usually because of enlargement of the prostate. It was excluded, because there is a belief that most men over 40 have at least some prostate cancer cells present. That allowed you to get rid of the low-severity cancers that are numerous and not very life-threatening at all.

A new classification system moved away from that staging to use another system of staging. But the trigger to that new staging was the advent of PSA testing, which automatically allowed suddenly a big influx of people to be recognized that would have been completely symptomless before.

The exclusion of the Stage A prostate cancer, which was meant to cover the low-severity cancer, was completely bypassed with a PSA testing, because the PSA testing automatically created a cancer that was a Stage B cancer. So although, by definition, you try to eliminate some of the lower-risk cancers, then your testing procedures—like in this case, PSA—might bypass the old system and create a new system. You'll end up paying a lot more claims than you thought.

Prostate cancer incidence had a really tremendous bump, compared to historical rates, because of PSA testing. Fortunately for us, the bump was limited in time to about five to eight years, as the people who should have undergone PSA testing before, but did not have it available, caught up with the testing. There were many diagnosed tests right there.

But to illustrate the fact that medical technology, contrary to a life insurance policy, mostly is against you in the sense that the better medical technology is, the earlier the diagnosis will be and, the higher your incidence rates will probably be as well.

Heart Attacks. Heart attack is a current issue regarding definition.
The old definition was based on the 1975 and 1979 World Health Organization definition of basically electrocardiogram change and raised cardiac enzymes. A new definition evolved in 2000 by the European and American Consensus Committee and used a different testing. It used the rise and fall of a myocardial necrosis marker, which is not an enzyme and one of the following symptoms: Ischemic symptoms, Q-wave abnormality, EKG change indicative of ischemia or coronary artery surgical intervention.

This new definition had multiple layers of impact on your existing policies. First, it's a lot more complex, and it's not incorporating your definitions. Second, a number of the triggers are difficult triggers for an insurance industry to manage. Chest pain is an ischemic symptom. So suddenly, with the rise of the enzyme and the chest pain, you have a diagnosis.

The second, the coronary artery surgical intervention, the rise of the marker plus an angioplasty or bypass is an automatic diagnosis of a heart attack. So now, instead of being protected by a 25 percent payout on angioplasty, the person has that trigger, and suddenly you have to pay the full amount. So this had a profound impact or is having a profound impact on how we're looking at heart attack definitions.

Troponin is now the indicator of choice. It was not, as I said, an enzyme, so a new definition that will meet the heart attack definition of today, if you see your cardiologist, most likely will not meet any of the definitions you have in your policy, although the cardiologist will be writing us and saying it is a heart attack, and you'll have a hard time defending yourself on saying it's not covered.

It has a very significant impact on the number of heart attacks diagnosed, maybe as much as 30 percent more heart attacks. Heart attacks are one of those factors that have a significant impact in your pricing.

Adjusting to New Definitions

The concern is, what do you do if the medically accepted definition changes substantially? What do you do if your definition starts to become out of sync with the medically accepted definition?

As we said, some of those products stay on the books for a long time. The heart attack definition has been good since 1979, but after a while, definitions change. It's unlikely that the definition would stay the same all the way out.

How Critical is Critical?

So how critical is critical? This still remains an unanswered question. Right now, we're still at the laundry list of events. Is there a need to go to severity trigger? How would that trigger be defined? I think it's up to pricing people to find out. The important thing that you need to do today is to make sure that your pricing is aligned with the definition of the event, especially if the person that does the research on the incidence rates is not the person that is writing the policy. 'There is a lot of interaction between your trigger definition and your pricing that is reasonably subtle, and that needs some thought.

MR. EDDY LEVY: I'm not going to tell you what critical illness is, because I think you've heard that a couple of times already. What I will cover is how the product fits in our portfolio of insurance products available in the marketplace; and second, how the product is being sold today. So as the marketing guy, I think it's normal

that I address marketing issues.

Product Fit
Where does the product fit? How does it fit within our existing portfolio of health products, of life products, of other products? The product seems to be a complement to several insurance products that we see in the marketplace, including major medical plans, disability insurance, cancer insurance, life insurance, long-term care, and annuities, believe it or not.

Major Medical Complement
Let's talk about the major medical relationship. There are significant gaps in our major medical plans, as you're all aware. For example, deductibles, co-insurance, travel and child care. Statistics coming to us from the American Cancer Society tell us that two-thirds of the costs associated with serious cancer are non-medical. What does that tell you? Your major medical plan will not address those costs. Let's look at some costs related to cancer. Experimental treatments with other medical expenses, home renovations, private-duty nurse, special vehicle for transportation, and child care.

I've also been looking into a couple of other things—things like kidney transplants, which would be covered by possibly your kidney failure definition or your major organ transplant. Well, kidney transplants are covered under Medicare for two years; however, the largest cost for a kidney transplant is lifetime prescriptions. These, although covered to some degree by the plans, have a yearly limit on costs. So once you've gone past your budget, everything else you're out-of-pocket-for. There's a nice opportunity to come in and cover that out-of-pocket expense by a critical illness policy.

Disability Insurance Complement
With regards to disability insurance (DI), how does this fit? This is acceptable either on an individual disability policy or for long-term disability (LTD). What I'm going to talk about here is, I think, applicable in both cases.

We know that for high income earners, they're probably going to be maxed out at a certain replacement ratio. How do you bridge that gap? How do you address that amount of income that is not covered, due to the maxed out replacement ratio? You can provide that with critical illness coverage.

You can bridge the gap during the waiting period. A lot of individual DI policies are sold with a 90-day elimination period. What happens for the first three months? Well, the financial planners tell us that we're supposed to self-insure, and have an emergency fund. I don't know if you have done that kind of planning. I personally don't, so it would be nice to know that after diagnosis of one of the covered conditions, there's a lump sum of $50,000, $100,000 that's going to come in the form of a check from my favorite insurance company.

There are other things, such as uninsurable income, occupation and medical history: These are issues that people in the disability world are often confronted with. Critical illness insurance can provide a solution—not in all cases, but in several of them.

My last point is about cannibalization. In talking to some insurance companies with an existing DI portfolio, there is a concern about cannibalizing the DI sale: For some agents and brokers, they may see critical illness as an alternative or replacement for DI.

The way I've always positioned it is, critical illness addresses extraordinary, short-term expenses—that spike that you see at the front end of the illness or of the disability. Whereas, disability insurance, as you all know, replaces lost income. So if you look at the way, the CI benefit is paid out in a lump sum; whereas disability is a periodic payment. That clearly tells you that it addresses two related but distinct needs.

So that would be a way to provide that information to the distribution system so that there is no overlap and there is no cannibalization. I think some cannibalization is going to happen. I think agents and brokers may see critical illness as an easier product to get through underwriting. There is very little financial underwriting concern for the lower amounts. Maybe from the mental nervous stress considerations, it's not as challenging; but by positioning it that way, you're identifying what need it's going to address.

Cancer Insurance Complement

With regard to cancer insurance, a couple of points: Critical illness covers the other statistically likely illnesses. So yes, cancer insurance is going to address the cancer issues, or most of them.

There are other things like stroke and heart attack; and you've heard about the other illnesses covered by my colleagues. That would be the way to position the product with regards to cancer insurance.

Some companies are doing it exactly that way. They're offering two options. They're offering critical illness policy that includes cancer, and a critical illness policy that has carved out cancer to wrap around an existing cancer benefit. For example, in the worksite marketing arena, if you've already sold cancer in the worksite, you've offered that to the employees and to avoid displacing that coverage, you would come in and offer a critical illness policy that does not include cancer but covers the other statistically likely illnesses.

A couple of other comments there: Those of you that are familiar with cancer insurance know that the current iteration of the product has a very limited chemo benefit. That is the most costly element, as we all experienced with some of the problems with cancer insurance. And so there's a way to position critical illness as

being able to cover the other expenses related to treating or having been treated for cancer.

Life Complement
Regarding life insurance, a couple of comments on that: We've seen this in the marketplace already. Critical illness is being offered as a rider to term—UL, VUL, etc. It can accelerate the death benefit—in other words, provide an early pay-out upon occurrence or upon diagnosis of one of the covered conditions. It also can be designed to provide a separate benefit.

There are advantages to both—there are some issues with regards to filing this product if it's an acceleration. Then it has to satisfy the accelerated death benefit regulations. If it's a separate benefit, then it doesn't fall under those requirements—is it health, is it life? So there are some issues to making one decision or the other.

With regard to the market opportunities of a rider to your traditional life products, there is the obvious opportunity on the mortgage protection side, and there's a statistic that's very interesting. It tells us that 48 percent of mortgage foreclosures are caused by the mortgage holder suffering a critical illness.

In the UK, which is the largest critical illness marketplace in the world, the vast majority of products are sold as part of mortgage protection. As a matter of fact, critical illness attached to mortgage life outsells traditional life insurance in the UK. That's just to tell you how popular the product is.

What we're talking about is an early pay out of death benefit, if a critical illness is contracted. By the way, that statistic—I heard it kicked around and finally found the source of it. Apparently, it comes from the U.S. Dept. of Housing and Urban Development.

I also would like to bring your attention to a very recent LIMRA article that's come out. It landed on my desk about two days ago, and it was very appropriate, because I was coming here to talk about this; so for those of you for whom CI has appeared on the radar screen, you're just getting to know the product, I would suggest you take a look at this. You know, look it up on the Internet, you'll find it. The author is Pete Jock from Market Research at LIMRA Intl.

Long-Term Care Complement
Concerning long term care insurance, we know that stroke is one of the primary causes or drivers of long term care need. Although long-term care insurance does a great job of providing you with the benefit required to cover your long-term care costs, it will not provide a benefit upon diagnosis.

So you could suffer a stroke, and in the initial stages, you may not have any cognitive impairments or loss of any activities of daily living (ADLs), but you have

suffered a stroke. The advantage that we see is a critical illness policy would provide you with that lump sum benefit upon diagnosis. As the condition deteriorates and as your long term care needs start to appear, the long term care insurance product comes in and takes care of that.

As a matter of fact, for those of you that read *National Underwriter* there is an individual in the March 25 issue talking about a combination product, and he suggests combining critical illness and long-term care insurance. That made me feel good, because I thought about that and I didn't want to be the only person who had a wacky idea like that. Someone else has a wacky idea, as well. And he's published.

Annuity Complement

With regards to annuities: This is a concept that was brought to my attention. A company approached us and said, "We're trying to think about a way to wrap critical illness around some annuity products, that we're currently selling." The idea would be, once a critical illness claim is approved, the account value of the annuity product would be increased.

So this is a different spin on how to do that: This allows the client fund to do double duty, addresses the concern about living income, and protects against the financial constraints of suffering a critical illness—a very interesting way of doing that. There are probably some tax consequences there. We've not explored it that thoroughly yet.

This product has been generating a lot of creativity in the marketplace, and people have been thinking about different ways to position it, to sell it, to attach it to other benefits and to other products. There's a good example of that.

How the Product Is Sold

Let's talk about how the product is being sold.
Critical illness is being distributed in the following ways: Individually sold, agents, brokers, worksite—we talked a lot about worksite today—and true group. There is a beginning of a marketplace on the true group side, and I'll talk about that a little bit.

Sold Individually

There are several companies that are experiencing success with a product like that is individually sold through agents and brokers today. The early success has been with companies that have career agents. Why is that? Any thoughts about the advantage of doing a product like this with a career agency? Captive agents? What would you see the advantage of that?

The feedback we got was with a captive agent, you're able to provide training and to a certain degree control what they sell and how they sell it. Training is the number one ingredient for success for critical illness insurance.

We've talked a lot about product design. I talked about positioning and all that is fantastic. But if you've not done a good job of training your distribution, be it worksite distribution or individual or even on the benefit consulting side, if they're not fully trained on the product, they're not going to sell it.

A good example of that or proof of that is, again, the UK market. In the UK, the first four to five years after the product was launched in the mid 1980s, there really wasn't much success with the product. Then in the late 1980s, early 1990s, a company called Abbey Life developed a comprehensive agent-training program. They happened to have captive agents, and they made a very significant effort in training their agents, and that resulted in immediate sales for them.

The rest of the market paid attention and they followed suit. If you look at a graph of the sales in the UK, you will see a spike in sales probably to 1993. One of the things that spike is attributed to is the development of comprehensive training materials for agents and brokers in the market.

On familiarity with other health products: The feedback we got is that companies that are selling other health products that launch an individual critical illness product will have better success, because these agents or brokers are familiar with the medical terms, are comfortable asking medical questions in underwriting, if it's a fully underwritten product. So there is some synergy if you have other health products.

Then you have companies also selling, on an individual basis, the life acceleration or additional benefit rider. The reason companies have adopted that approach is that they're competing in a very commoditized term marketplace, and they're all trying to come up with different bells and whistles to differentiate their offering. Critical illness is a great way to do that. It's providing the broker with a different story to tell, other than, I've got the hottest term product in the market, and a week later, Company X has come up with an even hotter product. Well, here's a benefit attached to your term that hopefully will differentiate and may allow you to retain that client a little longer than the whole replacement game that happens with regard to term insurance.

Worksite Sales

On the worksite side, we see a couple of versions—either an individual worksite product or a group voluntary benefit. There are advantages and disadvantages to both. Certainly for filing purposes, the group version is easier to file. Employers are facing a cost dilemma.

Regarding shifting benefit costs to employees: According to Watson Wyatt Survey, there is a trend towards doing that; hence, there is a demand for supplementary products such as critical illness insurance, in which the employer can shift the cost and have the employee pay for that.

Some of the worksite companies that we've talked to that have a critical illness product are having success at renewal of other products that they have. They see offering CI as a way to protect the relationship that they have with the employer group. So they're doing what's called expanding the share of wallet, which is going to help them to retain the existing business and offer a new benefit to protect the relationship as best they can.

True Group
True group product is, I would say, one of the newer developments in the very new critical illness marketplace. The idea would be to offer it as a true group benefit paid by the employer. One of the ways that's being done—this, again, comes from the *National Underwriter* issue of March 25—is offering critical illness as a base benefit to all employees, paid by the employer.

You're offering, maybe, $10,000 to all employees. You've convinced the employer that this is a valuable and important benefit. So the employer is prepared to pay for that base amount. Then you go back and re-approach these employees and offer them an opportunity to buy up. What this one individual has noticed is that, in other attempts to go straight towards the voluntary approach without the base, it's a more challenging sale, and the participation rates have been lower.

But if you're going to an employee who has already seen the company invest in them by paying for a benefit, that's raised their understanding of the product. It's raised the profile of the product within the company, and you're going to sell this to a more informed consumer. The participation rates have been better than on a purely voluntary basis.

MS. DYKE: I've had a couple of clients recently come up and ask me to help them develop either consumer-driven products or products that have a consumer-driven feature. What they're talking about with consumer driven products is, an insurance benefit in which the consumer gets to decide how to spend their money, such as a medical savings account or a rollover benefit if the insured doesn't use the benefit money in that current year. They get to save it and so they can use it next year. Well, critical illness really is a consumer-driven product, because we're paying out a lump sum, and then the consumer gets to decide what to do with that money.

FROM THE FLOOR: My background is in individual DI. What I'm hearing right now sounds a lot like our industry 20 years ago, where there is a growing number of diseases that are going to qualify, there's a shrinking number of gatekeepers, and the technology is leading toward trigger event incidents going up.
With our line of business, those that tried to compete wound up running hand-in-hand off a cliff. Do you see the same thing happening in CI? If not, why not?

MR. LEVY: I think that's a very valuable point. This product is at a stage where poor claims experience, legal battles over claims, and any bad press, are going to seriously impact its potential. The point I'm trying to make is, companies should

compete from a very responsible standpoint.

Adding multiple covered conditions, not doing a great job of developing your definitions, as Jean-Marc pointed out—those are all issues. Pricing is definitely an issue, and I think I agree entirely with that point. We need to be responsible at this stage. We need to be responsible throughout, but even more at this early stage, with the development of the product.

MR. FIX: The good and bad thing about this product, and very similarly to DI, is that your mistakes will come and bite you very quickly. So, just be very vigilant in your claims, and you might be able to correct your course if you're sufficiently vigilant and sufficiently prudent. But of course, don't run with the lemmings.'

MS. JACOBS: I agree with what they said, but I was also going to add that right now, luckily we're at the stage where there aren't many competitors. The pricing is not really easy to compare company-to-company, rate-to-rate. That's one of the reasons I stressed in my presentation on thinking through all of your assumptions. There isn't one real competitive rate at this point. Nobody is out there saying, "OK, you've got to charge $200 at age 40." There are many valid reasons why you can come up with a rate and probably still sell a rate that's double that.

So I think you have, at this point, the luxury of being able to have the margin if you want it and if you really research what you need to do. In the claims experience, at least for now, if you do the research, you can come up with a rate that is substantial and should be good, at least for the next few years.

Of course, as Jean-Marc mentioned, as definitions change in the market, you're going to get questions from your policyholders, such as "My policy says my heart attack is based on this. Now my doctor says a heart attack is based on something else." Well, you'll face that question then. Do you have to change the policy forms for everybody who is in force or not? How would that affect your rates?

You're not doing non-cancelable. You're pretty much going to be doing guaranteed renewable. So that helps, as well. But you have the luxury right now, that it's a new enough market that it's not that competitive yet. I would take advantage of that while you have it. The earlier you get in, at least you get some experience; you learn.

FROM THE FLOOR: I believe it was Clarica or one of the earlier adopters that actually put in their policy that every 10 years, they would review the definitions. But that was a marketing bomb. In fact, it was probably a positive for the consumer that things would be reviewed to stay in line, but they did not perceive it that way. They heard, "Well we're going to promise you this for 10 years, and then we'll change it, depending on experience."

Is that still the case? Are we starting to see these things integrate back into the contract form? Is nobody doing that now?

MR. LEVY: I think you're referring to the Canadian product for Clarica. I have the benefit of working on both sides of the border, and Clarica in 2001 represented one-fourth of the Canadian critical illness business on their own. They did make the change. I mean it was perceived as an issue in their product.

They have the benefit of selling the product through a captive agency force. Those agents have no choice. They have to sell their product. So they had success with and without that clause. I agree that having a clause like that makes sense; however, the Canadian market has become very competitive in a short period of time, and companies found that flaw and pointed at it.

FROM THE FLOOR: You don't think the trend is going to be in the U.S. to have things like that?

MR. FIX: No, I think the lesson was learned from Canada in that perspective. As much as I hate to say it, insurance companies are not the most popular organizations in the country, and especially health insurance companies. Anything that smacks of, "I'll change your policy form against your will" is really not going to be viewed positively at all.

The great point of this product is that, it leaves a lot of decision in the policyholders' hands. I think that's one of the pluses of the product, and some trend like this is not likely to happen. What will happen is possibly a change of definitions with a change in rates. That will have to be done very carefully with really a great effort to educate the client.

FROM THE FLOOR: Actually, I had a question piggybacking off of what you had mentioned, how this would integrate with consumer-directed healthcare. If someone has a heart attack or something, all of a sudden they have $50,000 to spend on health care benefits, my question is really how that plays with tax advantages in the United States. If all of a sudden you have $50,000 to spend, and you have the added restriction that it can only be spent on health care benefits, you get into issues of, can it carry over one year to the next? How long can it carry over?

Do any of you know anything on that subject? I mean, what I heard so far is that you can spend it on anything. Well, do you gain any advantage on just health care? How far has that been explored?

PANELIST: I think that will remain a question.

PANELIST: We don't know. We do have pretty strong assumptions that for a stand-alone health product, the payout would be tax free. The feedback I'm hearing

is, there are no restrictions on what you do with it. No one has, as far as I know, explored any specific target for the benefit, as you're suggesting. I've not heard that in the marketplace at all at this point.

FROM THE FLOOR: I assume the premiums are then, post-tax. You pay your tax in the premiums and then the benefit pay out is tax-free.

PANELIST: Yes.

FROM THE FLOOR: It's possible there's an advantage if you restrict the whole thing to just health care expenditures.

PANELIST: It is possible. I honestly don't know the answer to that.

FROM THE FLOOR: I'm not surprised, because the last I heard, there's been no final ruling on these balances under consumer-driven healthcare in the United States. Everybody is for it, but there's no clear interpretation right now in the IRS; so it's best not to have a ruling. I wouldn't be surprised if this would fit squarely in that unnamed category for a few years.