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Session 7PD
The Markets for Critical Illness Products

Track: Product Development

Moderator: SUSAN KIMBALL
Panelists: ABRAHAM GOOTZEIT
TOM MING†

Summary: This session explores the aspects and the issues of offering a critical illness product in various markets, including individual, group, worksite and direct response. For each market segment, panelists address product requirements, distribution requirements and assumption and experience differences.

MS. SUSAN KIMBALL: Hello, I'm Susan Kimball, Executive Director of Living Benefits at ING Re. ING Re has been in the critical illness insurance business about 4 years. I've really seen a change from a year ago having to tell our clients about the product, to this year, hearing them say, "Our agents are starting to ask for this product." So I feel that it's going to take off in the United States. I also have on my panel Abe Gootzeit, who is a consultant for AON Consulting. He used to work for Tillinghast, as my boss as a matter of fact. Abe and I have been in the business more than 15 years. I'm going to be talking about underwriting and regulatory issues today. Abe's going to be focusing on product design, pricing and risk management. We also have Tom Ming, who is a producer for Canada Life. Tom is a big producer, selling 70 percent of the critical illness policies for Canada Life. He'll be giving us a producer's perspective, which is not always available to actuaries.

I'm going to assume that there is a moderate knowledge of critical illness insurance in the audience. Most people know about critical illness issues, so I won't spend a whole lot of time on it. But for those of you who have not heard of this product, or heard much about it, it is a product that pays a lump-sum payment, on first diagnosis, of a specified critical condition covered under this policy.

†Mr. Tom Ming, not a member of the sponsoring organizations, is regional director of Canada Life in Arlington, Texas.

Some of the variations to this can be a series of payments versus a lump sum. We've helped our clients develop products that are tied to the mortgage market. For a lot of people, that's the biggest debt they have, so when they get a critical illness, instead of a lump-sum payment, this product would provide monthly payments that cover their mortgage.

The number of definitions covered is obviously going to vary company by company. In the United States, typically the number is five to 15, but in other countries, such as the United Kingdom, I think it runs as high as 40 or so. It'll likely get that high some day here, too. You can have pretty much any kind of product form as you do for life insurance, such as whole life, level term, and so on, with various payment periods. This product is in most of the markets out there, such as individual and group, direct response and voluntary worksite. The worksite market is where it has really taken off in the United States. The people in that market might make $20,000, $40,000 or $50,000 a year and, if they get hit with a critical illness while living paycheck to paycheck, they really need to have this coverage.

One reason is to pay their mortgage. It's interesting that three percent of foreclosures on homes are due to death while 48 percent are due to a critical illness. The individual market is also doing well, and more and more producers are selling in the high-end market. There is demand for this type of insurance, for example with partnerships: they probably have keyman life insurance, so that if a partner dies, the business can survive. But if a person gets cancer and has to be out for a year, it's also going to hurt that person's business. So that's getting more popular. Group has not been as popular, but in the past year, I've been hearing a lot more clients interested in a true group critical illness product.

Some of the most common conditions covered include life-threatening cancer, heart attack and stroke—what we would call the big three. About 80 percent of your claims are going to be from those three coverages. Pretty much all policies have those. Kidney failure and major organ transplant make up the big five illnesses. Most often those five are included in critical illness policies. When you're dealing with the worksite market, you tend to have maybe just these five or a few more, while you may see more like 10–15 in the individual market. If you want to get younger markets, you may throw in things like paralysis or coma, things that may happen due to an accident.

Some of the things that may be covered at 25 percent or less include coronary bypass surgery, that's typically 25 percent. Angioplasty, if it's included, may be at 10 percent, but I'm seeing that go away more and more with only about half the policies including it, since it is so common and not really critical. Carcinoma in situ is not as critical as life-threatening cancer, so that may be covered at 10 or 25 percent. Many worksite products include carcinoma in situ because a producer has limited time to discuss all products and it is hard to explain why certain types of cancer may not be covered.

Let's go into regulatory issues. The design of critical illness as a stand-alone product tends to be the most popular in the states right now, though I'm hearing more and more companies want the accelerated rider. The stand-alone product is a health product. An accelerated rider is considered a life product in most states, except California. The additional benefit rider is priced similarly to the stand-alone product in that it pays in addition to your base policy benefits. The regulatory environment is one of the most challenging issues with this product. The waiting period is the period from policy issue to the time benefits are paid. It's usually 30 to 90 days; we recommend 90 days for cancer since it is more anti-selective and 30 days for the other conditions. But there are 14 states that don't like waiting periods too much, so they do not allow a waiting period or have a maximum number of days, but you can get around that. You don't have to offer full benefits right away. You can, for example, pay 10 percent of the benefits for the 30-day waiting period in some of these states. Seven states have issues with return-of-premium benefits—they either do not allow a return of premium at all or you can only pay a return of premium if the insured dies from a no covered condition.

Some of the underwriting questions have problems. One of the questions is typically, have you ever had cancer, heart attack, and so on? There are three states that do not like "have you ever had" but limit this to "have you had in the last 10 years." Three additional states do not like family history questions. A few companies refuse to even offer the product in those states since it is important information. The family history question is typically, "Have two or more immediate members of your family had cancer, heart attack," and so on. These states look at it as being similar to genetic testing. Another unique requirement in Iowa and Washington requires a hospital indemnity benefit. They require that you have a $50 per day hospital benefit for up to 500 days, so there has to be an additional benefit on top of the critical illness benefit. Many of these requirements don't make sense in a critical illness policy, but that's the way it is.

Some states restrict what may be covered under the cancer and major organ transplant definitions. This may not make sense. Why would you not be able to cover a bone marrow transplant? However, if you're covering cancer, a bone marrow transplant is indicative of having cancer already, so it's probably already been paid out.

In California, they think that insurers don't do enough for women, so even though it's not a critical illness, you do have to cover mammograms. They don't have a specific dollar limit. What I've seen is $50 a year to cover getting a mammogram. They no longer require you to cover a Papanicolaou smear.

Loss ratios are obviously a big issue for health products. If your critical illness product has a 50 percent loss ratio, you're going to get by in most states, and even the states that don't have loss ratios still want it to be reasonable. So, 50 percent seems to be a reasonable loss ratio. Some of them require 55 percent; Minnesota just went from 65 to 60 percent. And some states are just generally difficult. They

have lot of different requirements. You should also note that this is a pretty new product, so if you refile and you get a different examiner or if it's a year later, and you send something in and you think it's going to get filed just fine because it was approved a year ago, they can come back with five new questions. That does make it challenging.

For the accelerated riders in Pennsylvania, you cannot have a pre-existing exclusion, that is, if the critical illness accelerated rider is on a life product and filed as a life product. You can do it if it's a health product or if it's a no-cost benefit.

In Oregon, the total premium must be waived on partial payments. If you pay bypass at 25 percent, then you can no longer charge a premium for the rider, and you can't charge a premium for the base plan either. You would just have no further premium, which is obviously a little bit scary. To combat that, we recommend simply having no partial benefits and only doing 100 percent acceleration in that state.

For group obviously the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is out there. Note that your legal counsel should be consulted regarding this and all other legal issues. However, the product may be exempt from HIPAA if it's a stand-alone product, if the benefits are not coordinated, and if it's not reimbursement based. ERISA, whether it's group or individual, will be triggered if it's employer paid.

Now for the underwriting issues. Critical illness underwriting is obviously different from life underwriting. A higher percentage of applicants will be declined. Things that might rate you up for life insurance, such as multiple conditions, are going to get you declined for critical illness, so that needs to be understood by the underwriters as well as the producers.

Typically, you want a smaller range of substandard than for life. We recommend going up to Table 4. Financial underwriting is going to be different. Life could be up to 20 times salary, whereas for critical illness it might be more like three to seven times salary, based on age. There are going to be additional questions in the application. We mentioned family history, the "have you ever had" questions, and sometimes, symptomatic questions, so those are going to be in addition to life application types of questions. The guidelines and ratings are going to be tailored to the specific market, whether it's worksite, group or individual. We'll get more into that in a little bit.

Producer education is very important. We've heard from many producers and marketing people that one of the biggest things that they have to get over is the underwriting that's involved, especially if it's an individual product. It may take them a while just to understand it, and they don't like people being declined. So they need to really understand it, to be able to go out and sell those products. You need to talk to them during the development of a program, and when we go in and

talk to our clients about product development, we always have the marketing people involved from day one. We're going to make sure that we're giving them a product that they want, that they can sell, and that they can understand, not just in terms of underwriting but product design.

You need to sell the producers on the need for this product. Producers are not going to sell if they don't understand the need or if they don't become passionate about it. The producers, like Tom, who really go out there and sell this like hotcakes, understand it. They know there's a need for it, and they're very passionate about it. Training is very key for the marketing people. If our clients are not willing to put the time and money and effort into training agents, they're not going to sell this product.

There can be comprehensive underwriting guidelines, especially in the individual market. You need to invest the time to fully explain underwriting decisions when they come through. Producers prefer simplified underwriting. Actually, they prefer guaranteed issue. As I'm sure you've all heard before, the simpler the better. Simplified issue can be fine if that's what's going to work to sell this, especially in a certain market, like the worksite market. But you obviously have to price for that.

Some of the concerns of underwriters involve definitions. You need to make sure that they're clear, concise, that they match up at claims time and in your pricing. Obviously we talked a lot about family history, because that's very important. Underwriters really hate excluding that in those certain states, because if your mom and your sister both had breast cancer, your chances of getting it are quite a bit higher, at least two times.

There is natural adverse selection with this product. It's a lump-sum payment. It's a living benefit. It's not paid based on severity, like perhaps disability income. So it has some natural selection.

Let's look at some things underwriters look for that can affect people for these critical illnesses. For example, in diabetes, underwriters consider age at onset more important than insulin use. With hypertension, again age at onset is important, and whether they have both hypertension and diabetes. What kind of medications and how many medications are they taking for this? If it's three or more, it may be a decline. Weight is also an issue. If you're underweight, it could mean cancer. If you're overweight, that obviously could lead to cardiovascular disease.

Underwriters do not like certain conditions, such as Alzheimer's and multiple sclerosis, mainly because they're so difficult at claim time. It is very difficult to judge if these people actually have these diseases. We recommend not including some of these things, because of the issues that are going to happen at claim time.

Once again, variations occur by product type. For individual underwriting, obviously you're going to get full evidence, similar to life. You're going to have nonmedical

under certain amounts such as $100,000, and for younger ages, like under 40. Large face amounts and older ages are going to have exams and be medical versus nonmedical. For substandard, often in the worksite market, you're not going to offer substandard, but for individual you may go up to Table 4.

There are going to be lower reject rates in the individual market compared to the worksite market, because in the worksite market, it's typically accept/reject, so you may reject people in that market that you wouldn't reject if you had a little bit more information and did individual underwriting.

It takes significant training to do individual underwriting. We've heard that disability insurance underwriters tend to be the best critical illness underwriters. It's more similar to disability than life, for example.

For worksite and direct response with simplified underwriting, you may have three to five questions on the application, including family history, symptomatic type questions, and "have you had" types of questions. Obviously, premiums are going to be loaded since it's simplified, and it is typically an accept/reject application. You want to look at covered conditions as to "have you ever had" questions. The family history questions and contributory diseases, such as high blood pressure and diabetes are very important. Also, you need to know smoking status and suspicious symptoms like dizziness and weight loss.

For group, similarly, it's simplified underwriting. You need to look at participation limits and group size limits. For larger groups, you may ask fewer questions than you do for smaller groups. There are industry issues. You may want to exclude miners and auto racers, especially if you cover accidental things like paralysis and coma. The product may be guaranteed issue if it's employer paid and 100 percent participation.

The riders can either be acceleration or additional riders, as we've discussed. Typically, you have an application supplement, so if it's attached to a life product, you can use the information that you get on your life product for underwriting the critical illness product. You need the additional questions, such as family history, as underwriting action is independent from the life product. So you can be standard for life and declined for critical illness.

In summary, keep the product design simple, especially if you're in a worksite, group or direct response type of market. Look out for adverse selection. Use senior trained underwriters—one client said he felt that this was as hard to underwrite as long-term care. Train your field force to understand the underwriting and the product, and just use common sense.

MR. ABRAHAM GOOTZEIT: I've been working as a consultant for more than 15 years, and I've been working as an actuary for almost twice that long. I have been doing this business for quite a while. I've also been working on critical illness and

long-term-care riders since 1987, so I've been around through a number of generations of these kinds of products.

Let's start with a brief description about the critical illness markets. I'm going to concentrate on the pricing and risk management issues. I also have some thoughts on the keys to a successful program.

We'll review the markets for a second. The marketing method may have a material impact on the pricing of this product, so the actuaries obviously need to be pretty conversational about the methods your organization is using to price and market this kind of stuff. For a little history, critical illness has been marketed for many years and sold for about 20 years in countries like South Africa, the United Kingdom, Australia, Japan, Canada and other places. My take on this is that critical illness has been sold successfully in other countries with socialized medicine. It has also sold well in Japan with its history of high insurance purchases and in the United Kingdom, since critical illness insurance there is an acceptable insurance product, required by lenders to protect the mortgages when people take out home mortgages.

The initial form in the United States was primarily cancer insurance, and the early U.S. attempts in the late 1980s and early 1990s to market other critical illness insurance have generally failed. So if you go back into those times, we had a lot of products, a lot of life and not much heat.

The earlier attempts were generally acceleration riders or benefits that were attached to life insurance policies that accelerated the life proceeds. Do you remember back in those days when this stuff was called "dread disease" insurance? It was really kind of dread and didn't have that kind of panache that critical illness has.

So the question might be, why has critical illness staged a comeback in the United States in the last five, six or seven years? I have a couple of comments on this. The insurers are always looking for product differentiation, and there's been renewed interest since about 1996 or so. My particular interpretation of that is that the NAIC illustration regulation was being discussed at that time, and I think companies were concerned that product performance of their universal life products and so on would converge across the industry. Product differentiation became much more important, and insurers started to look for a broader range of products to sell and knew critical illness was enjoying success in other places.

I think it may be attractive to people who are middle-aged and near senior. I think it's relatively easy to describe and understand; Tom will talk more about that later. You know, a producer may have 10 minutes to discuss it. Critical illness, I think, is something that can be described relatively coherently in a short period of time. Insurers are looking for products that promote peace of mind, and I think this product is very important in that.

Part of the description of this session mentions discussing several markets. Critical illness insurance may be attractive in many markets: individual, worksite, direct response, group, acceleration, riders to life and all sorts of great stuff. There's been an increase in activity in the worksite market in the United States. If you look at the number of critical illness policies actually sold, worksite is far and away the leader. There's also a successful example of a company marketing critical illness through its agency forces through replacement of an existing cancer-only policy. Some companies offer a critical illness acceleration rider to their group policies, although again, that's not quite as prevalent yet.

There seems to be some interest, but less success so far, in direct response. So again, the pricing actuary needs to keep all of this stuff in mind as he or she goes about doing his or her work.

I'm now going to turn my attention to pricing, which is what I'm supposed to be discussing today. I'm going to organize the pricing part into a few sections. First is methodology. Next is claim costs—you know, where do we find the claim cost information for this? Then there are other assumptions, which may or may not be important, and then a sensitivity analysis. We'll look at what some of the sensitivities to pricing on some of the assumptions might be.

First, the methodology itself for pricing a stand-alone product is really pretty straightforward. Actuaries would just use regular health insurance pricing structure and standard methodology. The premium for critical illness insurance is, in rough terms, comparable to whole life insurance for a comparable amount of life insurance. If you have a $50,000 critical illness policy and a $50,000 life insurance policy, premiums are roughly comparable, and of course, there's a lot of variation from company to company, and so on.

Company variations are based on a number of factors. There is the marketing method, the benefit pattern—does the benefit reduce at age 65 for example? The underwriting class—does the insurer offer male / female and nonsmoker / smoker rates. And there are other variations from one company to the next. That's pretty straightforward for the stand-alone design. The premium structure is guaranteed renewable. So, again, there will be a chance to change premiums over time with the changes in experience.

Next, we'll tie in the pricing methodology to the acceleration design, and this pricing methodology is a little more complicated. Luckily, not that many companies are issuing this right now. It is a lot more complicated for actuaries to price. It's generally a single-pool-of-money approach, because the same pool of money can be used for life insurance and to accelerate for critical illness. Again, we need to use a multiple-decrement model, and there's a conservation-of-mortality approach. In other words, those people who have an acceleration of their life insurance proceeds, generally at about 25 percent, are still in the pool for life insurance, and their mortality will be a lot higher. This should have a lot of elevated mortality, so

you need to use the conservation-of-mortality approach.

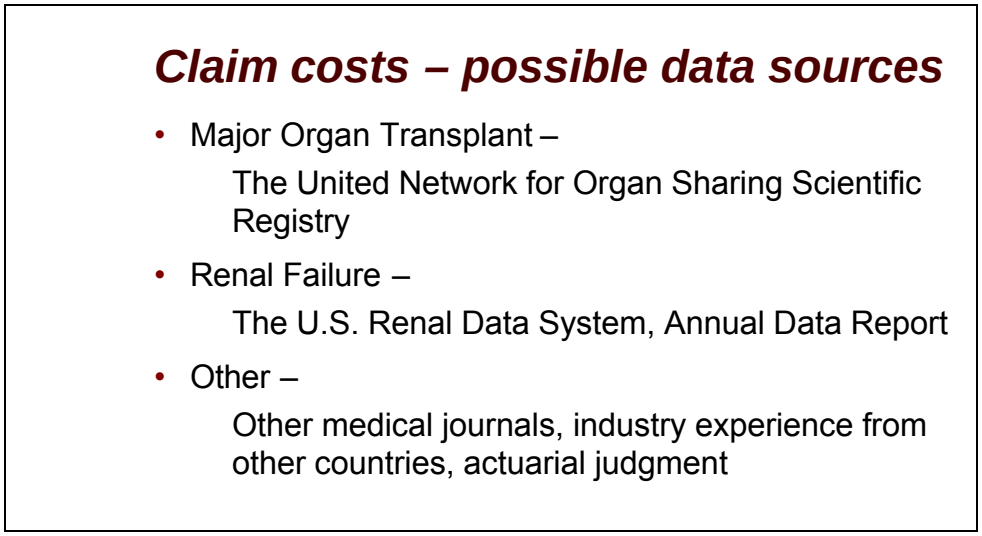
Therefore, there'll be separate assumptions for mortality and lapses for people with and without a critical illness claim. The key item for having an acceleration design is that there is a lower premium for the combined life insurance and critical illness acceleration rider than if you purchased the two policies separately, which makes sense. That's the most important reason for the acceleration design: because it is a compelling financial purchase.

We'll now turn our attention to claim cost assumptions. The basic building block of the claim cost assumption is from population statistics in the United States. We don't have credible experience in the United States for insured claims, so adjustments are to go from the regular population to the insured population. There is considerably more insured experience from other countries. We'll look at these things one at a time. Claim costs are really important for the critical illness insurance pricing exercise.

Generally you can look to the Centers for Disease Control as a data source for some of the big three or big five. For cancer, you can look at the American Cancer Society, Cancer Statistics Review or the National Cancer Institute for population statistics. For heart attack and stroke there is the American Heart Association and Heart and Stroke Facts. The one that has the best statistics that actuaries like to look at, that is broken down into the most comprehensive way, is the Framingham Heart Study with the 36-year follow-up. It has a lot of different variations and gradients.

Figure 1 shows different data sources for major organ transplants, renal failure and other kinds of diseases. Susan said that there might be up to 15 or 40 covered conditions. You know you need to be diligent about looking at medical journals, using your experience from the industry, and of course, your own actuarial judgment, which is my favorite kind of judgment.

Figure 1



What about experience from other countries? There really is a lot of insured experience from other countries. Actuaries in the United States need to be extremely careful about using that experience. Lifestyle, health and incidence of disease can be very different in other countries. The insured environment may not be similar; underwriting may be different; benefit design and sales processes and everything could be different. Just as a simple example, the incidence of heart attacks and strokes in Japan is considerably lower than corresponding incidence rates in the United States. So if you get an insured population from Japan, you need to use it very cautiously.

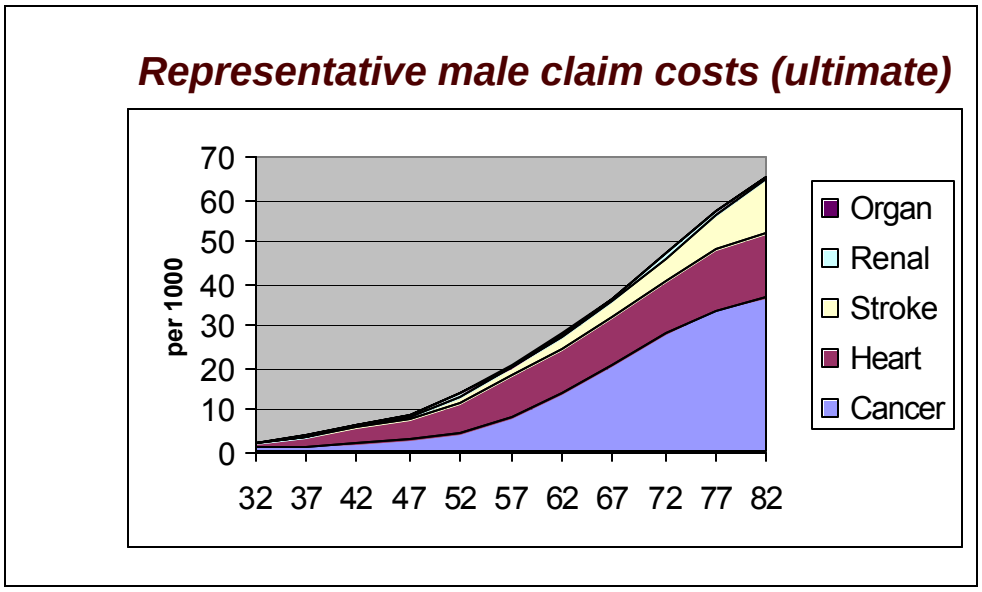
You're going to start with population statistics in the United States. How are you going to change that into insured statistics? First you need to have selection factors, so we need to reflect underwriting. That could reflect significant underwriting that may be done in some individually marketed cases, or you may have expected anti-selection inherent in simplified issue or guaranteed issue worksite and direct response situations. Again, we need to exercise a lot of judgment. If you have nonsmoker / smoker factors, if you differentiate premiums by that, it's preferred to look at the individual illnesses and try to get statistics individually for nonsmokers and smokers. Also, you could do something in aggregate, if that becomes too complicated. The credibility of the data must be assessed, and emerging trends have to be assessed and quantified as well. For

example, the incidence of life-threatening cancer is trending lower over a large number of years recently. So the question is, is that trend likely to continue?

The last thing is, claim costs need to be adjusted downward to remove multiple occurrences. Remember, you're looking at heart attack and stroke and everything else, and the population statistics have all incidence rates, while our policy only pays one time. The same person might have multiple heart attacks and a stroke and so on. Those statistics will be collected and calculated from the various places that you look; if you just add those together relatively, you're going to be overstating your expected experience. So make sure that you look at the multiple events situation.

Figure 2 demonstrates some representative male claim costs on the big five. Going from the bottom to the top, we see cancer, heart, stroke, renal and organ. I have a couple of observations. First of all, the claim cost trend rises rapidly with age. It's one thing that should be immediately apparent. Second, cancer, heart attack and stroke constitute most of the claim costs. These are the expensive things. A lot of the things that are added to go from three to 40 don't add a whole lot of expense. That's one of the reasons why insurers like to add lots of additional benefits, because they don't really cost much if they're well selected.

Figure 2



There are other assumptions besides claim costs that are very important when pricing critical illness insurance. They vary by market; things like selection factors, benefit design, lapse rates, expenses and distribution costs, and then average size and distribution by underwriting class. These are a few things. I'll look at those briefly by the markets that Susan included in our description.

First we'll talk about selection factors, and again, we'll look at this by marketplace. On the individual side, the anti-selection is possible, but there's significant underwriting, which Susan went through before. It's like a game that we play, and we try and do as good a job as we can to lead to acceptable selection factors.

On the worksite market, the level of selection factors really depends on participation rules and what kind of methods you're going to use, whether it's simplified or guaranteed issue and so on. Open enrollment is usually allowed annually, so there's going to be significant anti-selection that is going to be harder to control in the worksite.

On the direct response business, significant anti-selection is likely, and in the group marketplace, the selection factors are going to follow the group life, to which these policies normally attach. So really it depends on the characteristics of the group.

For benefit design on the individual side, you usually have this full range; you don't stop at five. Everybody has at least 10 or 15 benefits. So the benefits aside, you're going to have this rich range of all sorts of stuff in there. On the worksite, though, it's probably more important to limit it to a smaller number of contagions, to make sure that it's easy to communicate and describe in the limited period of time that

you have available. On the direct response basis, when you really have to do everything in the print media, then there really needs to be a very limited number of clinical illnesses and conditions.

For the group policies, it's common to include critical illness as an acceleration benefit for life policies. I guess "common" is too strong a word. The way it has been attached, when it has been attached, has been the acceleration benefit. Nothing on the group side is common.

How about lapse rates? Are lapse rates important? I see several people nodding their heads up and down. The ultimate lapse rates could be quite low in the individual market. We don't know what it's going to be like, but in other countries, the ultimate lapse rate is quite low. Remember, this product is lapse-supported. There are no cash values and it's level premium and the benefits go up rapidly with age. It's a very highly lapse-supported product, and for worksite and direct-response business, there should be high initial lapse rates, then lower ultimate rates are possible. The lapse rates for group life should again follow the group term life policy pattern.

I have a couple of comments on expenses and distribution costs. The most important one on Figure 3 is that on the worksite, there are fixed enrollment costs, and they must be spread over the policies sold. A lot of the ultimate profitability of the program is going to depend on what kind of penetration you get in the worksite. The same thing applies to direct response, because you have these high initial costs just to go out and do the programs.

Figure 3

Expense and distribution costs

Individual	Significant marketing and start-up effort, modest ongoing expenses.
Worksite	Fixed enrollment costs must be spread over policies sold.
Direct response	Unit expenses are heavily dependent on response rate
Group	Modest extra costs if sold as rider

Average size and distribution by underwriting class could impact the profitability, and it depends on the market. On the individual side, you usually have pricing by cell (by sex, age and class), and the premiums that you determine have equivalent profitability, so there's not an impact on profitability by the distribution. On the worksite, there could be significant distribution issues. In some situations, the worksite premium is the same for all—even for all issue ages. If that's the case, you need to be careful on the distribution, assumptions you use, how you price it, monitoring the experience, and that kind of thing. Again, it just depends on what kind of premium structure you're going to have and how important the distribution and the average size might be to the ultimate profitability.

We have a little example here. I am directing this question to you, so you need to actually look at this question. Figure 4 says, "Which change in assumption causes the largest change in premium, to achieve a fixed profit margin?" Fifteen percent increase in assumed claim costs sounds like it would have a pretty big impact. Four percent ultimate lapse rate instead of eight percent: I don't know if that sounds important. Then interest rates at 6.5 instead of seven percent.

Figure 4

Sensitivity Analysis

Which assumption change causes the largest change in premium to maintain consistent profitability?

1. 15 percent increase in assumed claim costs
2. Four percent ultimate lapse instead of eight percent
3. 6.5 percent interest rate instead of seven percent

Actually, it was a trick question, because the change in lapse rates is approximately equivalent to the change in the claim costs. A 15 percent change in claim cost obviously has a very material impact, about 15 percent higher premiums. Isn't that just amazing? The ultimate lapse rate going from eight percent to four percent has approximately equivalent impact on the profitability. Again, you need to be cognizant about the entire kind of program as you're pricing this thing.

I have a few more words to say on risk management, and then I'll sit down. We'll look at underwriting policy provisions and definitions in claims administration. There will be a small amount of overlap with what Susan said on the underwriting.

Susan already mentioned the underwriters will review the items listed here when assessing the risk of a critical illness applicant. So this is no different than what Susan had up there before. The point I'd like to make is the actuary needs to know the underwriting standards that are being applied to price the risk appropriately. It's one thing to say this is what you're going to look at; it's another thing to know how your underwriters are going to react to the information they get in accepting or rejecting or rating up the policies. Again, that should have a material impact on the way you price and come up with expected claim costs for your program.

Susan also mentioned the definition of critical illness. It's important that the definition of each critical illness be clearly stated, that the wording is accurate and correct, that it's consistent in every way that you communicate with your field force and in turn your field force communicates with your ultimate purchaser. It's important to make sure that you don't cover more situations than you're intending to cover.

Here are some common policy provisions that are designed to reduce the anti-selection and help meet the company's pricing targets for claims. Again, Susan went over a few of these things. There is the required survival period prior to benefits being paid, if you can get away with it. The alternatives that were mentioned are a waiting period or reduced benefit period at issue.

One other thing that's important as well is a reduction in benefit at older ages. There are some common policies out there right now that have a reduction in benefits at age 65 or over a five-year period between 65 and 70. The benefit goes down at the time the incidence rates go up, and that would do a number of things. Number one, it would keep the premium more acceptable, and it also would make it less lapse-supported. So that's a design that you might want to consider.

As for claims administration, I'm not a claims adjuster, so I can make comments that are completely inappropriate. Claims administration is generally easier than disability income. I think it is. However, it's more difficult than life insurance. It sounds pretty simple, that when somebody has cancer, you pay a claim, but there really are definitions that need to be adhered to and to make sure that the severity is met.

Finally, we have keys to success. For distribution it's really important that the home office people don't get really excited and design one of these things without having a couple of Toms around to sell it. I think that we've been guilty of doing that in the past, and it's nice to see now that there are some agents who are embracing the program and really selling the heck out of the thing.

It really is a good need-selling kind of product. It requires effective marketing and intelligent product management. Again, some of the things in the pricing effort sound straight forward, and we're used to doing these kinds of things, so you need to keep your head about yourself. Also, it's important for an organization to be committed to this line of business. It is something different, and it requires commitment and skills and knowledge to be successful.

MR. TOM MING: I normally only have a chance to talk to marketing groups, so this is a unique opportunity for me. First, much of what I will talk about is not from the perspective of a producer, but from the perspective of a regional director of agencies. My primary job for Canada Life is to seek out agents and to recruit them to our company. One of the ways I do that is by using critical illness as a recruiting tool. In fact, I tell them that. I tell them my goal is to hook you with this product and then get you to sell other products that we have. I speak on this topic and teach a lot of continuing education courses on it.

Like any salesman, let me start with a story. I remember a long time ago, hearing the story of a dog food manufacturer that invented a dog food that was so good, it was guaranteed to double the life of everybody's famous family pet. They hired a great sales force. They did all the empirical research. They had proof. They got the advertising in place, the distribution in place, and after an initial surge, they didn't sell any. They were very disappointed in this. They got their salespeople together and, as home offices are prone to do, they always blame the salespeople. They said, what's the problem? Meekly, in the back, one guy raised his hand and said, "The dogs don't like it." There's the question. What if the dogs don't like it?

The problem is not, in my judgment, whether or not the public will buy this product. This, quite frankly, is a simple product to sell the public, and I think you'll see why in a few minutes. The problem is trying to get the agents to sell this product. The public buys it, but the agents have been tremendously resistant to this product. After years of selling this product, I'm not completely sure why, but I want to explore what I hear all the time.

Normally what happens is what my company did. They threw a product out there and said, "Go get 'em." Nobody went and got 'em. Now I happened to fall in love with that product and really dedicated a lot of energy to it, which is why we sell a lot of it. But no other region that I know of, in my company, sells any to speak of. Consequently, we're responsible for most of the production. Training is much more than product. The question is, how do you go about doing that?

First of all, you have to get agents interested in this product from a marketing perspective, without offending them about what they're selling now. For example, you find out in a hurry not to say, "Well, nobody can live on their disability insurance" if that agent sells disability insurance. They resent that. You have to set that up. You have to soft sell that approach. I think what we really have to do is appeal to need and greed, and we also have to appeal to the expert. We tell agents

that if they get involved in this product, they will be market makers. They will be pathfinders. They will be unique persons, and their peers will view them, quite frankly, from a positive perspective.

We also believe greatly that this product, as I think you'll see in a few minutes, is a tremendous lever to open up doors to other markets. In other words, we tell agents, "If you get in this thing, you'll be an expert, and you'll make a lot of money, and you will also solve your prospecting problem." As companies, we need to look at this product, not just as something we're making money on, as in how do we price it, but also, perhaps, as an opportunity to get a bigger market share in some markets.

So we have to tell our agents why they need to sell this product, what the need is, how to sell it—that's the greed issue—and really, we need to motivate them. All salespeople need a dream. I mean, that's what salespeople do. They're following some kind of dream.

The topic of the discussion that I've given many times, and I think you'll find this to be true, is that modern medicine is changing the game plan. I was honored to speak at the Million Dollar Round Table, not this last session, but in the previous one, and what I find is that this product is just exploding around the world, and people really respond to it. Interestingly, when you get a U.S. agent in an international audience and they start to see how successful some other people are, then they start to really respond to it.

So we talk to agents. We tell them, "Look, our goal is to provide you enough information to determine if you should be in this market and to show you how to sell this product with confidence. We're going to show you an actual sales process, how to go through it." You know, interestingly, many of the producers today have forgotten how to sell. They've been involved in the replacement world and fortune world. They've been involved in all kinds of things, and the issue of a need sale is very, very hard to get across to many producers today. They've been out of that for a long time. Finally, though, we really want to talk to them about using it as a lever to open markets.

Why on earth would I, or anybody, get heavily involved in the critical illness insurance business, when we ran a very successful life insurance operation? A lot of people think we're crazy. Others think that we're just stubborn. For a long time, I spent an awful lot of my time that represented very little amount of our production. Now I spend not very much time at it, and it's probably almost 50 percent of our production, the critical illness market, because we have built that up. Again, we stress to our associates and our potential associates the opportunity of using critical illness as this lever to create new marketing opportunities.

The first thing we discuss with our agents is this. Is there a future in this market? They've been selling life insurance on the continent of Europe for perhaps 300

years. The concept of insurance goes back to the guild days. Critical illness insurance has been for sale in the continent of Europe since the middle 1980s. It now, in many places, is in excess of half of new premium income. In a very short period of time, it's taken over the market. There must be some reason for that. That typically wakes up the producer.

Again, for the purposes of time today, we won't get into all the details of the study, but all of the reinsurance studies and so on have found that the public is far more receptive to this product. In fact, they are seven times more receptive to this product than they are to a new life insurance sale. As we tell our producer or potential producers, the commission levels are the same as for life insurance. There are a gajillion companies out there. They all have basically the same life insurance products, or most of the life companies do. Would you like to have 1800 competitors or would you like to have just a few? They relate to that. Finally, we point out that some of the markets that are traditional in the life insurance business—split-dollar estate planning, all those things—are under severe attack. Even inside buildups are under severe attack, so they better start to change while the change is good.

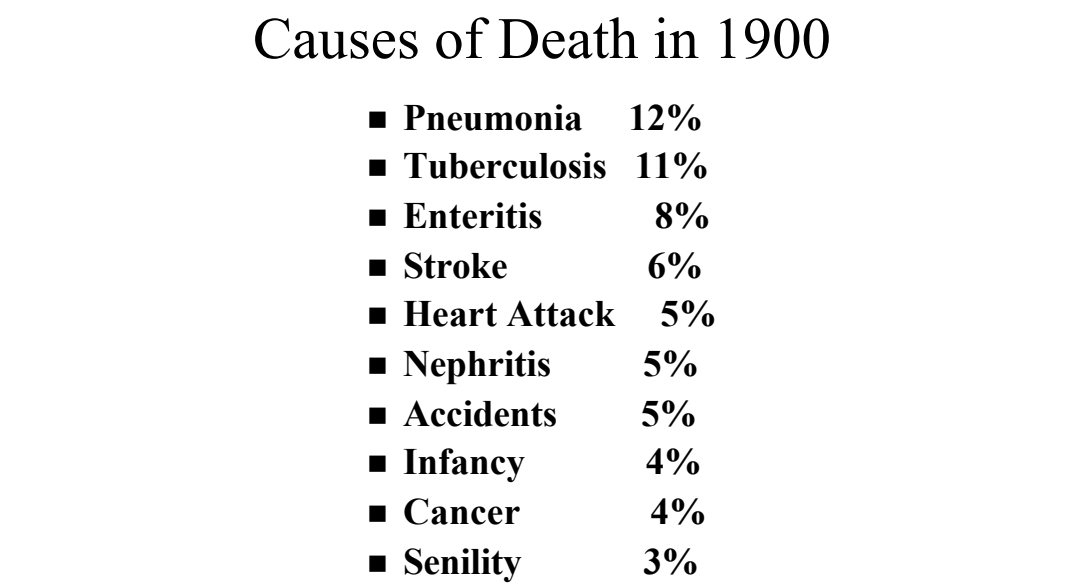
Interestingly, we find group insurance agents are very receptive to that. They know that it's just a question of time before they're out of business, at least in the judgment of some of them. We tell them that we see critical illness insurance to have tremendous upside potential, that's why we got into it.

How do you sell it? The first thing we have to tell our associates is that critical illness is not a sales process; it's an education process. You need to put away all of your old "let's close hard" kinds of sales tools, and create a new way of selling. We talk about the fact that modern medicine is changing the game plan, that the medical profession has actually created an insurance dilemma. People are today living longer and longer. We introduced Dr. Marius Barnard as the founder of this. He is a fascinating person for those of you who have not had a chance to hear him speak or meet him. In fact, in Vancouver, there's an international meeting coming up in January, and I think Susan will be at that, on critical illness. People will come in from all over the world, and Dr. Barnard is the lead speaker.

He would point out this simple fact. In 1900, when life insurance was in its heyday, men lived to an average age of 42 years and women lived to an average age of 46 years. They died of causes that we don't hear much about today. I'm always fascinated by the fact that enteritis, whatever it is, and nephritis, whatever it is, killed more people than heart attacks and strokes and cancer, just a few generations ago (Figure 5). Today we live to be in our middle 70s. Quite frankly, if we live in rural areas, we'll probably live to the middle 80s, based upon just today's numbers. Paradoxically, however, we live a far worse lifestyle. Today we deal with carcinogens and air pollution and water pollution and asbestos poisoning and all kinds of bad things like diet habits. I love this line by Dan Clark, who is a professional speaker. He said, "I was born in the South. We didn't even know what

cholesterol was when I was growing up. But even if we'd known what it was, we'd have fried it." Is that not descriptive of what we, as a society, do? Dr. Barnard would say, "Only in America do you see people eating a triple cheeseburger in one hand and a Diet Coke in the other."

Figure 5



Source: Life Tables 1900 - April 1998

We can go on and on with these things. Stress is obviously a big killer. The major causes of death that we talk about now include heart attack, stroke and cancer. These three alone will kill two thirds of all of us. Here's another major statistic I find interesting. Today, in our country, 4,000 of our fellow Americans will have a heart attack; 2,000 will have a stroke; 4,000 will go into a complete fog as their physician tells them for the first time that they have cancer. That is a horrifying moment. That's 10,000 incidence rates of heart attack, stroke or cancer. There will only be about 7,000 deaths in this country today, for all reasons. So that's why I started to say modern medicine is changing the game plan. The incidence rates of these three illnesses alone are in excess of the death rates for all of us. Typically, companies will have 10 or 12 illnesses, 30 overseas and 40 sometimes. Again, modern medicine is changing the game plan. I'd like to point out to the gentlemen that men get cancer more than women do, and we don't know that. Typically, men take terrible care of themselves and pay no attention to health. Women, I believe, are probably better marketing people of this product than men are.

This statistic also hit me pretty hard. When I was born in 1945, the stroke survival rate was less than 10 percent. Today it's closing in on 80 percent. As Figures 6 and

7 show, that's an extraordinary increase in the survival rate for strokes. The reality is that most of us hardly ever return to work once we've had a stroke. Medicine is keeping us alive.

Figure 6

Stroke - Survival

- 4 million stroke survivors are alive today
- Survival has increased almost 700% since 1950
- Survival Rate in 1950 = 11.2%
- Survival Rate in 1988 = 69.9%

Source: American Heart Association - 1998

Figure 7

Stroke

More Often Disabling Than Fatal

31% Stroke survivors need help caring for themselves

20% Need help with walking

71% Need help with work

16% Are institutionalized

Source: American Heart Association -1998

One of the things that we also point out is cancer costs. Most of us think, "I've got a good medical plan; this is wonderful. Everything is fine. I get cancer; I'm fine." No. Two thirds of the costs associated with cancer are nonmedical. Now what's that? It's obviously lost wages. It's trips to and from the cancer treatment centers, taking a loved one, traveling with one. It's all of those kinds of things. It's experimental treatments, and believe me, those are expensive and highly necessary if you are the one with the cancer. We have seen situations where fortunes have been drained out of families because people are trying to stay alive. No money or no insurance means no experimental treatment.

Obviously, the bottom line is people are living longer and longer. If insurance is something that should provide dollars, and I believe it is, insurance is something that we should use to bring money back to people when they need it the most. What I find fascinating is that the life insurance business, in particular, is fighting every year about who can have the cheapest term insurance policy, and it's going to pay one to two percent of the people that ever buy it. That makes no sense to me. That's why I think the time has come for critical illness insurance. Dr. Barnard would say, "You need insurance, not just because you're going to die, but in fact, because you're going to live."

Figure 8 covers some interesting statistics. There are three times more heart attacks than people that die from them. There are three times more strokes than people that die from them. There are three times more diagnosed cases of invasive cancer than people that die from them. So we can see that the need is pretty high.

Figure 8

1997 Incidence vs Mortality

	Incidence	Mortality	Ratio
Heart Attack	1,500,000	500,000	3:1
Stroke	500,000	150,000	3:1
Cancer	1,450,000	500,000	3:1

Figures 9 and 10 show some statistics. Let's take 45-year-old men. Seven percent of healthy men age 45 will die by the age of 65. A whopping 25 percent will suffer a critical illness and live. Now since two thirds of those that die will die from heart attack, stroke or cancer, you can see where this product starts to fit in with starting to protect people. The same thing is true for women; they just don't have incidence rates or death rates as high. Among 50-year-old women, four percent die and 16 percent suffer critical illness and live. These are 4-1 ratios.

Figure 9

Probability of Death, Disability for 180 + Days, or Critical Illness Claim Prior to Age 65

Male Age	Critical Ill	Disability (Unisex)	Death
35	29%	19%	9%
40	28%	18%	9%
45	25%	17%	7%
50	20%	16%	5%
55	13%	13%	4%

Figure 10

Probability of Death, Disability for 180 + Days, or Critical Illness Claim Prior to Age 65

Female Age	Critical Ill	Disability (Unisex)	Death
35	24%	19%	7%
40	23%	18%	7%
45	21%	17%	6%
50	16%	16%	4%
55	10%	13%	3%

Typically then, after we've done this with producers, we would go in and show the product, and we would conclude with the same statistic that Susan gave earlier. Obviously, if somebody has lost their home, it's a sign that economic times are bad. Of all the mortgage foreclosures in this country, three percent are due to death; 48 percent are due to critical illness. The reason we point this out is we're trying to set up this issue. Having said that, what does it cost?

One of the big problems we have with agents, but not, by the way, with doctors, is they think it costs too much. These are typically agents who have been shopping for the cheapest term insurance out there, but you have to set up the cost. Because if you let that thought or that seed take root, that agent will never sell critical illness insurance. So we want to set it up with statistics before we get to that point, and we make sure that they understand it. Then we would give cost. Clearly, if we're talking to an agent who does small sales, we're going to use small examples. We set up this one for people that were in the doctor market. So we'll go through different kinds of products.

It is true that we have 100 percent chance of dying. However, in this room, 80 percent of us will suffer a critical illness and live, generally speaking, long before we die. Modern medicine is indeed changing the game plan. Economic disasters are far more likely to happen because people get sick and live than because they die prematurely.

I'll talk about a couple of quick techniques and then we'll conclude. We often times

use this when we talk to the public, or quite honestly to the agents. We say, "If you do what I tell you, the next time you're in your church, or synagogue or mosque or temple, a place of worship, pull out the bulletin and look at the prayer list. These are people who have gone to the Almighty. Half the congregation that go to the Almighty go because their problems are so big they cannot solve them. Count the number of people on that, because somebody has died. Now count the number of people on that prayer list, because somebody has got one of these covered conditions, and you will find out in a hurry what the biggest problems are out there, today."

We've covered underwriting. Typically with producers we talk about incidence of illness. We talk about the balance between family health history, and between health and family history, because family history is a big issue. Often, we will use the family history question as a close in a sale. We would say something like this. "Mr. Prospect, we know, as I've described to you, that family history is a big deal here. Now obviously, your family history is different from my family history. So your standard rate would probably be different from mine. Let's apply based upon your family history and find out." If they come back Table 2 because dad died of a heart attack at age 55, I go hot dog! We got the standard rate based upon your family history. That's the basic standard rate for somebody who has had a parent die prior to age 65 of a heart attack.

Marketing is where you would think it would be. It's in all the places that Susan and Abe have covered. We've gone through these things. Obviously, where people have been denied disability insurance because they're on Prozac, or something like this, would be a great place to start.

The biggest mistake I see in this product more than anything is nonbelief. If the producer does not buy into this thing, in their heart, and that generally means that they buy the product and want to sell it to family members, then they're not going to sell this product.

Let me conclude with the idea of perhaps building a lifetime annuity. This always fascinates agents. I could not get my own agents to sell this product. So I picked up the telephone and called the Texas Medical Association (TMA). It took me a year from that phone call, but I got an endorsement from the TMA on our product. Then I got an endorsement from the Dental Association, Hospital Association, and all the other groups shown in Figure 11. We got more prospects than we can keep up with. I won't tell you the story of who sold the TMA, but it was basically a woman with cancer. We have formed a subsidiary corporation to work with the TMA. They are basically our joint venture partner, a group called Texas Financial Services, Inc. What do we sell? Clearly we sell critical illness insurance. We're also selling lots and lots of life insurance. We're selling long-term care. We're selling pensions. We just went in the 412I business. We sell group insurance. We sell disability insurance. Figure 12 illustrates where we are doing a series of asset protection seminars all over the state of Texas through approved attorneys and advisors. I get to pick the

financial advisors, of course; that's my thing. Who opened the door to this wonderful opportunity? Marius Barnard did. I couldn't have gotten into the TMA and worked with 40,000 doctors otherwise. Our goal, simply stated, is to lock up markets using critical illness as the key to get in that door.

Figure 11

Associations

Texas Medical Association…TMAIT

Texas Dental Association

Texas Hospital Assoc …THA/Healthshare

Texas Society of Medical Staff Services

Dallas Society of CPA's

Oklahoma Bankers Association

Oklahoma State Medical Association

Oklahoma Rural School Districts Association

Figure 12

Attorney & Financial Advisors Network

For a quick recap here, I want to read you something and I'm going to shorten this up too, because we're about out of time. Marius Barnard was gracious enough to write a foreword—this was the first draft of it—to a book at a couple of our requests. So he wrote this foreword:

> On December 2, 1967, I played God. I walked into the Groote Schuur Hospital one night to perform a perfectly ordinary procedure on a 55-year-old patient named Louis Wochanski. He was a diabetic with incurable heart disease. He had two choices. Either a short wait for death or risk transplant surgery with an 80 percent chance of survival. Because of his choice, the world would never be the same and neither would I. That first human heart transplant our surgical team performed that night changed the course of history for the world, for my brother and for me, and we didn't even take a photo.
>
> We had no idea what would happen to us the next morning when we finished that procedure. Prior to that we were simply the Barnard brothers, two of four sons born to a poor Afrikaner preacher in a small arid town of Bofard, West South Africa. The next morning we were world famous. It sounds rather romantic and exciting. After all, the heart is the soul of the body. My heart belongs to you. You broke my heart and soul. And the truth is, to us, it was just another procedure.

> Doctors have been transplanting kidneys for almost 13 years and no one seemed to notice. For some reason, the heart was more important to everyone. The ticking of life, the soul of another sacrifice, so that one might live. To me it was just a job. And my job was to improve not necessarily the quantity of life, but the quality. Mr. Wochanski lasted only 18 days. Not exactly quantity or quality, but he was succeeded by more thousands who would have both.
>
> Indeed, I still see people today who survived heart transplant surgeries 30 years ago. The problem is, they're not coming back to thank me. They're coming back to ask me how they can go on living. They were bankrupt and it wasn't from the transplant cost; it was from life after salvation. They were dying from living. 'Dr. Barnard, I had to stop working after my operation. I can't pay my mortgage. I can't pay for my children to go to the University. I'm going to lose my business and my home. What can I do?' I was stunned; I was angry. It was now me with a broken heart and not them, and I had to do something.
>
> I want to change the ideas of insurance, I told an insurance company president who sat quietly at his desk in South Africa. I want to see people given compensation at the very point of diagnosis, not after they've died. I want insurance for the living, not the dead. Enough money to pay them for whatever they want to do, not just some short-term disability check that runs out right before they're forced to go back to work. To my surprise, he thought it was a good idea, but informed me that he would need more evidence. I left his office and never returned.
>
> Thirteen years later, when someone finally came back to me, I got involved. The insurance company wanted to sell a critical illness insurance product. Would I be interested in assisting them with the definitions? Seven pages and four definitions later, critical illness insurance had been developed in the first country in the history of the world. It was simple but life saving. Today I am no longer a former partaker in fixing broken hearts. Today I mend lives for generations to come."

My friends, I believe that modern medicine is changing the game plan, and I believe we, as producers, or we, as companies, need to adjust to that.

MS. KIMBALL: That was great, very great, what Marius Barnard has said.

MR. RONNIE KLEIN: For the last six months I had the opportunity of working internationally, so I've seen critical illness. I wrote a whole bunch of things down here, because unfortunately, I'm not a big fan of critical illness. I've seen how much money companies have lost in the products. I'll start backwards and reverse. It's a

really good sales pitch, all the things that you're saying, but all these people that are in need of this product, and it's growing, cost the company a lot of money. So it's just the opposite. You know, that's the great thing about life insurance. People are living longer and companies are making money on the product. So it's really easy, I think, to sell a product that's maybe underpriced in certain areas, and here I'll give you some examples.

In the pricing, do you look at these new medical techniques that are coming in and some of these diseases that are on your list that are being diagnosed early? That's a big concern of ours. You get these things earlier, so life insurance people are living longer. You can pay longer, but critical illnesses are being paid sooner because of new detections that are coming out. So that's the first question. How much do you add in the pricing for that, and how much do you add in your pricing for potential lawsuits? For example, in Australia, I don't know if you're aware of the case of a person who had a heart attack, but clearly not a heart attack as defined by the policy. It went to court. Everybody agreed it was clearly not a heart attack defined by the policy, but the judge said to pay him. It's a critical illness. He had a heart attack; it's a critical illness. How much do you add for pricing of that? Those are the two questions that I have.

Again, I'm really stunned at everybody saying how successful it's been around the world, when a lot of countries are losing money on critical illness. The other thing that I would tell everybody to watch out for, in pricing this, is right now in Asia, they have some plans that have over 80 definitions of critical illnesses. I'm really concerned about these add-ons, because you had mentioned that add-ons don't cost a lot of money, and they do. They cost a lot of money because you need someone to have the know-how of what they are when the claim comes in, so you need claims handling. Expenses are very high on these additional definitions, plus people don't really understand it. It could be that we detect them sooner. For example, carcinoma in situ, I can't understand how that is a critical illness. I just don't understand it. Those are all things that I wrote down. So would anybody like to respond to them?

MR. GOOTZEIT: In reverse order, I agree that carcinoma in situ is not a critical illness. Not being a critical illness is the same definition, but it is required by certain states, and it has found its way in there. You're certainly correct in stating that care needs to be taken. I think care does need to be taken in the pricing of these programs. You made some good points, and I think that those points need to be characterized and priced into the program. You're absolutely right, and I do think that in the United States, the determination of claim cost is still a lot more experimental than it is experience based, so there are a lot of care processes that need to be taken into account. I completely concur with your primary thesis, that we are going into places where we don't have a lot of insured experience in the United States, and it does require more care. I think that the portion of my presentation on the pricing was to alert people on some of the possible methodologies that are required and some of the available claim cost sources and

some of the processes that people can follow in order to go from population statistics to insured statistics. I think everything that you're saying is absolutely correct and I applaud you for that.

The fact that the program can be successfully marketed, and that at the same time we have little experience in the United States, should not necessarily be something that we're afraid of as professionals or as an industry. I think that there's nothing wrong with using our best judgment, using all the knowledge we have to come up with prices, which are appropriate under the circumstances. You could have made the same exact kind of statement about long-term care insurance, as an example. Over the past few years, the profession in the United States was not that comfortable with the way it was pricing the program. It did have good market penetration; it was accepted by the population, and as experience becomes more available, the industry adjusts. I would concur with that here as well.

So I think all the points you're making are factual points, but I don't think that means that in the United States, that we should abandon this as a program.

The other point I think you brought up was the discussion of the claims and whether or not they were covered. That's not a new issue in medical insurance in the United States. That does happen on occasion, and the industry does need to adapt to that. In health insurance, it's always the case that there are additional kinds of things that are required to be paid for and covered, and that's the situation here as well. We need to be extraordinarily careful that the definitions appear sensible. They can be communicated clearly. They are communicated clearly. They encompass the kinds of things the population expects to be covered, and again, care needs to be taken in those areas. So I guess I agree with all the things that you're saying. The one place where I would disagree with you is I think that you're negative on the program. I'm not sure entirely if you're negative on the program only because insurers are having difficulty making money or if you have a more deeply rooted kind of a problem with the marketplace.

MR. MING: Let me also take a shot at that. I agree with you as well. I think what you're saying is, it's a pricing issue. It's not a need issue. My job is to go sell this stuff. Your job is to go price it. I don't have a problem with that. It's very interesting to me, since we operate so heavily in the doctor market, that I've never had a doctor tell me this policy costs too much. I've had lots of agents tell me that. So it's very interesting that they know what's going on. I don't disagree with you. I tell you this, though, the field force in this country is getting old. Quite frankly, for a long time now, they have been like a bunch of guppies living off each other's young. That's really what's going on in the marketplace. There's about the same amount of life insurance being sold by fewer people. Pretty soon, when those people retire, we're all going to be out looking for new positions, if we don't come up with some new creative things to get in the marketplace where we're actually covering need. That's why I think critical illness is so important at whatever price we have to do it. However, we may have to redefine the definitions. I think it's a

critical product to have in the marketplace.

MS. KIMBALL: I just wanted to comment as well, and I realize it's not always easy through the states to increase your rates, but at least in the United States, we have most typically shorter guarantees. We have maybe one to three-year guarantees on our premium rates. In other countries, where they are having more problems, they have a 30-year or lifetime guarantee. That certainly is a big difference. If you can't change your rates, obviously that's a much bigger risk than if you can change your rates.

MR. MARK SHAW: I'm wondering to what extent in the underwriting process we are underwriting relative to number four of the big five, renal disease and particularly polycystic kidney disease, which is a genetic disorder, but is easily detectable by ultrasound, years before someone actually is diagnosed with polycystic kidney disease? In any case, I'm just wondering to what extent people were addressing that in their underwriting process at the current time.

MS. KIMBALL: I'm not actually an underwriter; I'm an actuary speaking to the underwriting issues. To be honest, I don't have an answer to your question. I'll go back and find out and get your card and get back to you.

MR. EDDY LEVY: I actually have a comment about the earlier questions from this gentleman, specifically, on the topic of medical advances and the impact that's going to have on this product. There's no doubt that as medical technology gets better at diagnosing some of these illnesses or at earlier detection, we're going to have to be on our toes in terms of the impact that it's going to have on claims. However, the other side of the coin is also possible. It's likely that at some point, we're going to cure some cancers, and that's going to have a positive impact on our claims costs. So, there are two sides to that argument. I just wanted to point that out.

MR. GOOTZEIT: I might also point out that it seems to me that one of the safe ways to go is group. Obviously, you have experience rating. You can get out of it, if you need to. If I were just going to dip my toe in the water, I'd probably take that technique.

FROM THE FLOOR: I think I agree with Ron Klein too. We've seen other markets in which I think the insurance companies have not made money on the product. Anyway, one of the things that I think that we were also quite concerned about is the litigation risk that was also mentioned earlier. There are a couple of items that I just want to point out. One is on underwriting. I think there were comments made on replacement of income on disability income. I just wonder about the financial underwriting side of things, how their disability income is looked at or how that is viewed. Second, I was curious about Figures 9 and 10 on the incidence rates. I'm quite struck that the critical illness incidence rates were higher than the disability incidence rates, especially at the younger ages. I thought that would be a subset of

disability insurance. In fact, I thought critical illness in some markets is sold, instead of disability insurance, because it's cheaper.

MR. MING: I don't remember exactly, but let me give you an opinion on that. It's possible that you could have an incidence rate of some of these illnesses and get paid for them and not be disabled. I think that's why that is.

FROM THE FLOOR: How can your slide show disability over 180 days plus?

MR. MING: What's the percentage of the population that would suffer a disability in excess of 180 days? The critical illness rates were higher than that because you could have a critical illness be paid in a lump sum and not be disabled for 180 days. That's why that is. Secondarily, on your question on underwriting, in our own case, typically we would take three to five times income plus debt and not worry very much about the amount of in-force disability. One of the sales things we talk about is that it seems to me to be counterproductive. We have this great American dream to live a comfortable lifestyle, and yet if we become disabled, the antithesis is there, where the disability company wants us uncomfortable. In other words, they want us back to work, and I understand that issue, but it's contrary to the completion of a personal goal. For example, we routinely put life insurance inside qualified plans and say, if you die, your family needs the money. There's a far greater probability that contributions in the qualified plan are going to stop due to an illness than a death. From an underwriting standpoint, back to that question, three to five times income plus death.

MR. KLEIN: I didn't understand the comment from the floor that if we have a cure for cancer, you'd still have to get cancer, which means you'd get paid on your critical illness policy, and you wouldn't need to get paid on it. If you eliminate cancer, and I think maybe that's what was meant, then there will be a whole new repricing on the product, and the product will be a lot cheaper. On the other hand, one of the other comments was, what if things don't get better? Well, the problem is that if things get worse and you raise your premiums, you may not have a chance to raise your premiums in time to make up for it. Maybe it'll work in some markets.

The other thing is, it's very interesting how on a critical illness, they may get paid, but they may recover within the 180 days and not get disability. I don't see the need for the product in that situation. My last point is, I don't understand the lump-sum nature. For example, in the United Kingdom, it's sold as an acceleration, and you can pay off your mortgage. Well, I can't pay off my mortgage now, when I'm healthy and working; if I get disabled, I can't pay off my mortgage because I get disability income, which helps me pay the monthly payment. But if I have a critical illness, if I decide to go in and get an angioplasty, then I can pay off my mortgage. I don't understand why you wouldn't have a monthly set payment.

MR. GOOTZEIT: Well, again, I view things from a marketing perspective, so we're

coming at it from a different viewpoint. Let's suppose I have a heart attack and I work in a high-stress job. I could be off work for six weeks and be forced to go back into that high-stress job because I can't afford not to, because I'm no longer disabled under the definition of disability. I'm able to perform most of the functions of my job, whether I want to or not. Recognizing that I'm going right back into the stress environment is going to cause another heart attack. Now if I have a lump-sum payment, maybe I have the money set aside to train for something less stressful. From a marketing standpoint, that's sort of how I see that whole issue.

Now again, I don't hear any arguments about whether or not there is a need for the product. What I'm hearing is, we need to figure out better ways to price it, and I don't disagree with that. There's clearly a need for the product.

MS. KIMBALL: I have a question for Tom. You mentioned that consumers are about seven times more receptive to critical illness than life? I'm just curious as to where that came from.

MR. MING: That actually came from a study in Canada, where a big national telemarketing survey was done, and the group is divided into two parts. As you know, in Canada, taxes are very high, and one part said, there's a brand-new tax-advantage life insurance policy that's available, but we're curious to whether or not you'd want any information on that, or would you like to talk to an agent about it. I think five percent of the people said yes; 95 percent said no. Then they came out with another question to the second group, the control side. This was, there's a brand new insurance product out there that will pay a lump sum if you're just diagnosed with an illness. The same question was posed, would you be interested in talking to an agent about that? Thirty-five percent of the people said yes. On a telephone survey, there was a seven times greater receptivity to that product, and other studies that I've seen have had similar results. In other words, the public likes this idea of this product. We all know more people at our age who have been diagnosed with these illnesses than we know people who have died that are our age. So by our own life's experience, we're more interested in this product. It's also something that pays us, which is the second part of the equation on why people are interested in this product.