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Session 11PD
Critical Illness Insurance—A Stroke of Genius?

Track: Product Development

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Summary: Critical illness (CI) insurance has been widely sold in the United Kingdom. but has yet to find a place in the U.S. marketplace. Panelists discuss the current climate for CI insurance.

MS. SUSAN KIMBALL: Every year that I've been speaking on CI, it's obvious that interest is growing, and that's really great to see. I work for MetLife. I've worked there all of seven months, but before that I worked for a reinsurer and have been involved in CI for about five years. So, it's very exciting to be at MetLife, where we're introducing group and individual CI products, and I think having some bigger companies in the market will really help this to take off.

I'm in the product development area, so I work on product design, state filing issues, competitive research and the like. I also have with me John Cathcart. He is vice president and actuary with Gen Re LifeHealth and is responsible for managing CI and Medicare Supplement businesses. He's been with Gen Re for five years. Prior to that, he spent 16 years with Colonial Life & Accident, doing pricing, valuation and financial analysis. He has bachelor's and master's degrees in psychology. He is a member of the Academy and an FSA.

Marcia Johnson is vice president of sales support and strategies for Old Mutual Financial Network. Previously she was chief operating officer and senior vice president of Worldwide Health Benefits, where she led a team of CI marketing and

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training professionals to assist direct writers in launching, administering and distributing competitively priced CI products. Marcia has more than 22 years of experience in life insurance marketing and has previously held senior marketing management positions with Canada Life, New England Financial, Metropolitan Life and ING.

While she was director of marketing for Canada Life, Marcia was responsible for organizing a team that launched one of the first individual CI insurance products lines in the United States. She got the help of Dr. Marius Barnard, who's the father of CI. They did a great job of introducing that product. Marcia serves as a board member of the National Association for Critical Illness Insurance and is a member of the National Association of Insurance and Financial Advisors (NAIFA) and the National Association of Independent Life Brokerage Agencies (NAILBA).

I will be focusing on product design. John will be talking about pricing and underwriting in relation to different product designs. Marcia will talk about marketing the high-end product and give some case studies on that.

I wanted to start off by reading a few quotes from an article that came out recently from Life Insurance Marketing and Research Association (LIMRA). This article first quotes Tom Ming as saying, "Critical illness insurance is the greatest single opportunity that we will have in our insurance careers. CI is a product that everyone needs and nobody has. What an opportunity!" That's a great way to say it, and it really is quite an opportunity. It's the long-term-care or universal life (UL) of this time in the country. The market for CI protection is broader than the market for death protection. That really hits home. We sell a lot of life insurance out there, and there are singles or younger people who might not be thinking about life insurance, but they might know somebody who's had a heart attack or cancer and would be interested in this product.

The article says that in the early stages of a developing market, a good time to enter is just after a very large, well-respected company enters the market. So, now might be a good time to do that. Sales can be expected to grow exponentially for quite a few years into the future. You could expect it to double each year, and that is a very reasonable target, according to LIMRA. Ten million in the first year could grow to 320 million in the sixth year. So, it's a great market.

For those of you who might be new to CI—briefly, it pays a lump sum benefit when a policyholder is diagnosed with a covered condition. There are some out there that do more of an indemnity or scheduled benefit. That's a little different than what we're calling a true CI product. It can protect your assets. You might say, "I have my 401(k), and I have this and that, so I can self-insure." I personally want to retire early, so I want to save that money for my retirement. I don't want to use it if I get a critical illness. It can replace lost income. People might say, "I have disability." But most people can't live on 60 percent of their income, and this can help when you are out and not always getting disability.

When your spouse takes off to be with you and travel with you to the Mayo Clinic if you have cancer, then it can help with the spouse's lost income as well. Obviously, it can offset expenses that aren't reimbursed by other insurance, and that's not only medical expenses, such as experimental treatment, co-pays and deductibles. Again, if you and your spouse are traveling to the Mayo Clinic, you have the airfare and the hotel. Someone I know who has leukemia spent $1,500 per month on parking alone, so those kinds of expenses can really add up.

The majority of CI products cover cancer, heart attack and stroke, or the big three—and that'll be about 80 percent of your claims—and also typically cover major organ transplant and kidney failure. There are certainly companies that have thrown some other conditions in there, but these really are the ones that people are concerned about and that will cover most of the claims. It's nice to keep it simple, especially in the group and worksite markets.

People are surviving. About 20 years ago, the five-year survival rate for cancer might have been more like 40 percent, and now it's about a 58 percent survival rate. They're surviving heart attack and stroke as well. If you have a heart attack, you may not want to go back to your high-stress job. So, you go to another job and make a little less money, and you need some proceeds to help you do that.

Some of the trends in the health-care industry really support CI insurance. There is significant cost-shifting from employers to employees. We're probably all getting affected by that. High-deductible health plans and health savings accounts (HSAs), I'll talk a little bit more about that later. The top-tier hospitals and doctors are opting out of networks. There really can be a difference in your survival rate if you go to the doctor or hospital that is best for your type of cancer or whatever it is, and so you may be paying out-of-network charges to be able to do that. The managed-care system is limiting treatment choices, and consumerism is elevating insureds' control over their health lifestyle.

Let's talk about some of the issues to overcome. Education is key. It is especially important in the individual market to educate producers and consumers. We did some focus groups, and everybody said, "I already have this insurance. I don't need it." It took about 20 minutes to get them to realize what the product was, that they did need it, that they didn't already have it and that there would be a lot of costs that were not covered by current insurance. So, that's key, especially in the individual market. As a company getting into this product, you have to really involve the marketing and be dedicated to that education.

The marketing folks tend to say, "There's too much underwriting. I don't like the underwriting. I don't like family history questions. I don't have to ask that on life insurance. Why do I have to ask that here?" And again, it's education—obviously, family history's very important for the CI product—and they do get used to that. If they're life agents, they'll have more issues than if they're health agents. The cost

is higher than life insurance, and we'll see a slide in a minute that can help to make the case for why this is a higher cost product than life insurance.

For product design, you do need to look at the competition. That doesn't mean you have to copy the competition, but it's nice to see what's going on out there. Look at the different things they're offering and do the cost-benefit analysis. Return of premium on death, for example, I think is a nice thing to have. The consumers really like that, but it obviously adds to the premium. So, you have to work on that.

My slide about death and critical illness also includes disability of 180 days or more (Kimball page 30, slide 1). If you look at age 40, which is pretty close to the average age of people buying CI insurance, they have a 26 percent chance of getting a critical illness, an 18 percent chance of disability and an 8 percent chance of death. That's more than three times the probability of dying at age 40, so that's why the premium will be around three times higher.

We'll go to product design. The markets for CI insurance are group, worksite and individual. It's doing pretty well in the worksite market. People are pretty aware of it. Employers are aware of it. Group is just recently taking off, I believe, and there's a lot of interest there. Individual is where there's so much potential, but again, there needs to be a little more education to really get it going in the individual market. The types of products include stand-alone. In the United States, it's typically a stand-alone CI product. It can also be an additional rider. Most companies are not offering that, but it could be an additional rider, which is similar in design and pricing to stand-alone and pays an additional benefit, typically a rider on life insurance. Or it can be an accelerated rider, so it would accelerate your life proceeds. But it can also be combined with other products. I know there's one on a disability product right now. So, new and exciting things are happening out there.

As for underwriting, it's typically fully underwritten for individual and simplified issue for worksite and group. There is some guaranteed issue being offered out there at small amounts if there's certain participation and certain sized groups. HSAs are really in the news. If you watched the debates, you heard President Bush talking about them. There's a lot happening there, and it's nice that you can sell CI alongside an HSA, and I'll talk a little more about that later. Wellness riders, scaled benefits and additional occurrence benefits are some of the things that are making the product a little jazzier, and I'll discuss that as well.

Let's talk about selling alongside the high-deductible health plans. Many employers are going to these plans. Basically under the plans, the deductible is at least $1,000 for individuals, $2,000 for families, and the out-of-pocket is $5,000 for individuals and $10,000 for families. Fifty-two percent of employees are living paycheck to paycheck, according to a study that MetLife did. And this is not just people who make less than $50,000. It includes people who are making more than $100,000. It's amazing that people making a good income are really living paycheck to

paycheck and spending their money, so if they get a critical illness, they really will have to dip into their 401(k) or take out loans to be able to pay for that.

CI insurance can cover these high deductibles, so it works very nicely. When you have a $5,000 deductible, it's nice to have CI insurance that can help you pay that deductible and out-of-pocket. It gives employers, if they are in that market, a chance to offer a needed product. They're going to these high-deductible plans. They're making the employee pay more. Employers actually are very excited to be able to offer something like this to their employees. It does help to offset the ill will towards employers.

You have to have a high-deductible health plan in order to offer an HSA. You put your money in pre-tax, and you need to spend it on medical expenses to be able to take your money out. Unlike the flexible-spending accounts, you don't lose it at the end of the year. It's just becoming really hot. They basically say you cannot have it alongside other health products, but they've exempted long-term care, disability income (DI), vision, dental and CI. CI is considered a permitted insurance to offer alongside an HSA, so that was good news. There was some recent Treasury guidance that CI insurance applies to products with one or more diseases. It originally said, I believe, "one disease," and then it came out that it's one or more, so we knew that CI was, indeed, a permitted insurance. There is no guidance on the use of HSA funds in conjunction with the CI insurance benefits. I think the CI product works very nicely alongside an HSA.

Wellness riders are very popular in CI products right now. They don't all have them, but quite a few do. Typically you get a $50-per-year benefit for certain screenings, such as stress tests, blood glucose, cholesterol, chest X-rays, mammograms, prostate specific antigen (PSA) tests—those kinds of things. The cost is about $24 to $40 a year. It's less than $50 because some people will forget and not use it. Since you'll have health insurance that will cover this, it's good that it's a rider because it's not really that necessary. You probably have it covered by your health insurance. However, people do like it. It kind of makes them feel warm and fuzzy that you care about them and are being preventative and finding conditions earlier.

Again, I think it's important to keep it simple, but there are some products that are adding a little complexity by having scaled benefits. It does make sense that you would pay less for cancer or a heart condition that is less severe. A certain product out there is a rider that has four categories of severity, from minor to life-threatening. Minor might be a 25 percent payout, up to life threatening, which is a 50 percent acceleration payout. The payout does vary by age, so it gets higher as you get older. That's kind of interesting. As this market grows, I'm sure we'll see more things like that.

For additional occurrence benefits, there's a policy currently that does offer this as a rider, and it pays in two different ways. It pays on a second or third condition. So, if you have cancer, you get your face amount and, as long as you pay your

premiums, your policy stays in force. Then you have a heart attack, and it will pay again, a second time, and will go all the way up to three times face. But you do have to be diagnosed 180 days after the prior diagnosis for that to pay. The other way it pays is on the second diagnosis of the same condition, so it's a recurrence type of benefit. But again, it has to be separated by two years of being treatment-free. That one, I think, will be quite a bit more expensive and certainly will add to the premium. Not that many people will get cancer and then have a heart attack, but certainly if you have cancer, the chance of it recurring, or if you have a heart attack, the chance of having future heart problems down the road, is pretty high. It's a nice benefit, though. Producers and consumers do like the fact that the policy does not go away after the first payment. Again, you have to do the cost-benefit analysis and look at the premium. I think it's important to offer these benefits as riders so that you don't price yourself out of the market.

What are some of the trends out there? Covered conditions will always be looked at and added to, and it'd be nice if we kept it simple, but I'm sure we'll probably go where they're going in other countries, which is up to 60 conditions in the U.K., for example. I don't think we have to cover mad cow disease here, but they do in some products covered in the U.K. About half the products have a survival period now, and the trend seems to be that companies are going away from that. Typically, the survival period provided that if you were diagnosed, you needed to survive 30 days before you were paid. It makes sense because this product is about survival. You have life insurance. You don't really need it on death, but consumers and producers really hate it, and it doesn't add a whole lot to the cost because most people do survive. So, most new products are not including that.

Some are going to more of a modular design in which they're splitting out cancer because employers may already have a cancer product. You may not want to let the person choose, so you would just do this in the employer market and let the employer choose whether he wants to offer maybe just the big three—cancer, heart attack and stroke—or add a few more onto it or maybe have another Cadillac version with everything. That lets the employers think about the premium and work with that as well. Offering a monthly payout versus a lump sum might be nice for people who want to make sure that they can afford to pay that mortgage payment every month, for example. Then there are the combination products that I mentioned earlier. Combining it with not just life, but DI or long-term care has a nice fit. I think we'll see more products like that coming out.

As I mentioned, you can have the premium returned on death from a non-covered condition. That's a nice thing to have for the producers, who can say, "It's a win-win situation. You'll at least get the return of premium if you die." And adding some ancillary benefits, such as recommendations for best doctors. There is a Web site and right now, if you went to it, you'd have to pay. If included in your policy, you could go to it without paying. It basically tells you which are the best hospitals and doctors to go to for your specific ailment. Those kinds of things are nice to have in the product.

Dr. Marius Barnard, if you ever have a chance to meet him, is great and is so passionate about this product. He basically says you need insurance not only because you're going to die, but because you're also going to live. This is a great benefit for people who survive. I will turn it over now to John.

MR. JOHN S. CATHCART: Susan talked a lot about what CI is, what the need for it is and some of the product designs that we're seeing in the market and where it's going. What I want to try to do is expand on a number of her comments and talk about some of the pricing implications.

I'll briefly outline—because a lot of it is some of the same things that Susan was talking about—product design issues, marketing issues and underwriting issues, all of which have pricing implications. I'll talk a little bit after that about pricing assumptions, and then I'll try to wrap it up with a few comments. One of the things that's important to consider with your product design, marketing issues and underwriting issues is that things line up. It's easy to say, "This product looks neat. Why don't I use it in this market over here?" Well, it might not fit. You can't answer questions about marketing issues without also considering the implications for your market on the product design and underwriting.

Product design issues include the product structure and the features of the product, and I'll talk a little bit about some of the types of benefits that you might see. Susan, I think, pretty much touched on a number of these issues. The first question you have to ask yourself is, what kind of product do I want? Is it to be a stand-alone policy, or is it to be a rider? If it's to be a rider on a life policy, will it accelerate the life benefit, or is it an additional benefit, which, as Susan indicated, is really more like a stand-alone product to begin with? I think your market will determine the extent to which you're going to have an individual product or a group product. You may be very active in both markets, and you may develop different products for the two markets, but I think that they'll look quite different. Your underwriting obviously will be different, and your pricing structure will be different. The renewability of the product will be different.

There are a lot of different rate structures in the market. I think most of what we see is issue-age rated, but you do see some attained-age rating. The ratings could be step-rated or individual-age rated on either an issue or attained-age basis. If you're a rider on a life product, your rating structure will follow the rating structure of the life product to a large extent. There are tobacco-distinct rates. It's very typical. Tobacco rates tend to be significantly higher than non-tobacco rates. There are sex-distinct rates, and there are unisex rates. I think you're more likely to see the sex-distinct rates in the individual market. You're more likely to see unisex in the group market and the worksite market. Even individual products in the worksite market tend to be unisex.

As for renewability, basically as a health product, a stand-alone product, most of what we're seeing in the individual market is guaranteed renewable to age 65 or for

life. I think it's more likely for life, but it's guaranteed renewable, meaning that you do have the option to raise rates on a class basis, subject to regulatory approval. In other countries, you're more likely to see rate guarantees. I think that in Europe for a long time, rate guarantees were very popular. What I'm hearing is that people are backing off of rate guarantees. Basically a non-cancelable form of the product, I think, is still the most popular form in Canada. Personally that scares me.

Product design features include a waiting period, which is almost an additional form of underwriting. Typically, the policy has to be in force for at least 30 days, and in some cases 60 or 90 days for cancer, before you're eligible for benefits. Particularly in the worksite market, that does provide an additional measure of underwriting protection. I've seen some products that had no waiting periods other than for cancer, but virtually everybody that I'm aware of does have a waiting period for cancer. I'm sure there are probably some exceptions out there.

Susan has talked about the survival period. The policy is designed to provide a benefit in the case of survival, so you would expect a survival period. But from a marketing standpoint, it's really hard to tell somebody, "If you die on the 29th day, and you have a 30-day survival period, you won't get any benefit." There is a cost associated with it, but you have to balance the marketing considerations there. There are some alternatives around that. One is that you might have a reduced benefit if they die during the survival period. You might want to try to get creative. It does have an impact on cost, and I think that one of the things that's important with this product is affordability. It's a new product, and it's real easy to make it real fancy and real expensive, but affordability, I think, is one of the issues that must be addressed to make it a more popular product. One other comment on the survival period—to the extent that the product you're selling is an accelerated benefit rider on a life policy, the survival period becomes meaningless. But it is something that does have a cost associated with it for stand-alone and additional benefits.

Preexisting condition exclusion is a common provision in a health product. It's something that people will be familiar with, and that is something that may become more important to the extent that you're in the worksite and have simplified underwriting. To the extent that you're in the individual market with higher face amounts and are more fully underwritten, I don't know that the preexisting condition necessarily will provide you with a whole lot of protection.
The benefits that are provided by the policy cover, as Susan mentioned, basically five core conditions: cancer, heart attack, stroke, renal failure and major organ transplant. Additional conditions that we're seeing include paralysis; terminal illness within 12 months; coronary artery bypass graft, or heart surgery, which is typically a reduced benefit; and carcinoma in situ, which is also typically a reduced benefit that you're paying. On those last two conditions, you would typically pay 25 percent of the face amount or something less than 100 percent. The policy remains in force for the remaining 75 percent of the face amount.

One of the things that's very important with covered conditions is the definitions. If you have very loose definitions, you'll probably pay a lot more claims. If you have very stringent definitions, you'll end up paying fewer of the claims that you really don't want to pay. You're really trying to target, I think, more serious conditions. In that regard, it's very important to look at your definitions, have your doctors look at your definitions and understand what the implication is for the benefits that you might end up paying.

Your benefit amounts will vary. Marcia will talk more about marketing in the high-end market, and I think that will be more of an individual product. For worksite, the average will probably be less than $50,000, and probably closer to $30,000. I've seen some companies that are even lower than $20,000. If you plan to get into the individual market, you'll start seeing companies that will get up into $200,000 to $250,000. That market has been a lot slower to take off, and I think Marcia will address those issues. Obviously the benefit amount will have an impact on what level of underwriting you'll use. The higher the benefit amount, the tighter your underwriting will be.

Susan also addressed multiple payouts—paying for more than one condition or paying for the same condition recurring. Obviously that has an impact on pricing, particularly if you pay for more than one cancer or more than one heart attack, but even to some extent if you pay for a heart attack and then pay for a stroke. I think there's some co-morbidity there, and I think you need to look very carefully at your pricing on that. It's becoming more popular, and it's something that we need to look at very carefully.

Once again, I point out that we want to keep this product affordable, too. Therefore, benefit reductions are important. Most policies, if they're guaranteed renewable for life, will have a reduction to 50 percent of the benefit at age 65 or 70. The cost of the product becomes somewhat prohibitive if you're paying full benefits once you get well into the retirement years.

Susan talked about wellness benefits, and she talked about return of premium benefits. Both of these will have an impact on pricing, obviously, not only for the cost of providing the wellness benefit in and of itself, but also, what is the impact of providing a wellness benefit on the incidence rate for your core product? If the wellness benefit is an opportunity for somebody to diagnose something sooner rather than later, in effect, you pay the benefit sooner rather than later, and it may increase your incidence rates. I think that might be the case with some of the cancer tests that are going on. I think that some of the other tests that you'll see in wellness benefits may actually have the opposite effect—that you would be able to detect conditions that are likely to result in a heart attack, and you can start taking corrective measures to avoid a heart attack. It's not clear to me in the aggregate what the impact is. I've had some doctors suggest to me that the savings that you get from being able to conduct a test that would allow you to take preventive

measures against a heart attack outweigh the additional costs that you might incur on the cancer side.

Let's turn to return-of-premium benefits. Obviously you'll price for the return of premium itself. A return of premium benefit also tends to enhance persistency. If you'll have more policies persisting into the later years, when your morbidity is higher, even though you price for the right morbidity at that age, your present value of benefits becomes greater to the extent that you have more policies that persist into those later years. Those of you who are in the long-term-care market are well aware of that problem.

I'll talk a little bit about marketing issues. Susan's already covered a lot of this about marketing issues with regard to individual, worksite and group sales. Worksite sales can be either an individual or a group product, but what I'm talking about there is something that is a strictly voluntary sale. As I believe we've already mentioned, individual sales typically will have higher face amounts. You'll have higher persistency. You're more likely to be fully underwritten. Hopefully you're fully underwriting if you're starting to sell $100,000 and up. You probably will have lower limits for blood tests in attending physicians' statements (APSs) than you might for corresponding life policies. I think that your distribution in the individual sale will be the distribution system that's used to selling life products. But I think your life agents like selling life products, and there's some education that needs to occur. I think Marcia might address some of these issues in terms of how do you get them interested in a new product?

Typically on your individual sales, you'll also have higher first-year commissions, similar to your life commissions. Worksite sales, as I indicated, may be either group or individual. One of the issues that you need to think about when you're pricing the product is, is it portable? If you're selling an individual product in the worksite, it's almost by definition portable, but will your voluntary group product also have a portability feature or a conversion feature? You're typically looking at lower face amounts largely because you have more simplified underwriting. You would tend to have maybe seven to 10 questions on your application, and they are knockout questions. If you answer yes to any of them, you're not eligible for the product. Basically in worksite sales, the reason for that is that you have maybe 10 to 15 minutes to sit down with an employee. During those 10 to 15 minutes, you basically have to explain the product, which in all likelihood they haven't heard of before. You have to go through the underwriting, and it's a form of mass production.

A couple of other issues are associated with worksite sales. You typically will expect much lower persistency. Your persistency in the worksite is a function largely of employee turnover. In some industries, you know that the turnover will be high due to the nature of their business, particularly in the early durations. I think that even in the later durations, you'll still have higher lapse rates than you would on a life product. I think that you do need to be aware of the possibility that you'll have very

good persistency in the later durations, but you do still need to be concerned about very poor persistency in the early durations.

Participation level is important. Typically, particularly if it's an individual product, you won't have participation requirements, but I think you have to have a good knowledge of what your likely participation is. I think that what you need to be sensitive to is your participation on the CI product. If you're in the worksite market and you have a number of other products, and you say, "We're getting 20 percent participation overall, so that's good, so we'll just add a CI," I don't think you're getting very good participation if CI is only 1 or 2 percent participation by itself. You have simplified underwriting. You're looking for some of the benefit of being in a group market with a large number of policies and a spread of risk. If you're only getting less than 5 percent participation, you probably need to be doing more individual underwriting.

It's really important to understand what the enrollment conditions are. Obviously, you only have 10 or 15 minutes per employee, but it's important to be able to talk to as many of those employees as possible. If the employer says, "Here, I'll give you a list of all my employees, and you can call them at home and go talk to them there," that's probably not going to do a whole lot for you. You really need to have the support of the employer to talk to as many of the employees as possible on a one-on-one basis in order to get your participation up.

There are some occupations that you probably won't want to approach. That will be to some extent from a morbidity perspective but also from a persistency perspective. You are still paying, probably not 100 percent first-year commissions, but a high first-year commission and lower renewals. If you're in an industry that has a lot of employee turnover, you'll have high lapse rates, and you'll have a hard time recovering your acquisition costs.

For your group sales, basically what I'm talking about is an employer-paid product, which typically will be very low face amounts and may be added to your group term life coverage. You may have employer-paid with an employee buy-up. In some cases, it will be fully employee-paid on a voluntary basis, in which case most of the considerations for worksite sales also apply. You may also have some prohibited industries. Obviously you don't want to cover a lot of asbestos workers if you're going to provide cancer benefits. With the group product, you're looking at some guaranteed issue, as Susan mentioned, subject to size and participation requirements. Then I think you're looking at much more level commissions.

Let's turn to underwriting issues, and once again these have already been touched on. You have fully underwritten products. You have simplified issue. You have guaranteed issue. The fully underwritten more likely will be the individual market, simplified issue in the worksite and guaranteed issue in the group market. To the extent that you're in the worksite or group, you need to look at the protection that might be provided by some of the other product features. A waiting period, for

example, might provide some underwriting protection. Particularly if you have a guaranteed issue product in the group market, I think it's important to have a preexisting provision. Obviously in the worksite and group markets, as I've already suggested, you're looking for a spread of risk, and participation is important. Conditions hopefully are designed to enhance that participation in order to get a decent spread of risk. Your underwriting is not the same as life or DI or long-term care. There are exposures to these covered conditions that might be life-threatening, but it doesn't necessarily mean you'll die. As one of Susan's slides indicated, the likelihood of survival is very high for most of these covered conditions. For disability, you won't necessarily be out of work. You might change your work style. You still will incur very significant expenses, but you don't have to be out of work to collect the benefit, nor do you have to go into a long-term-care facility. You don't have to meet the activities of daily living (ADL) definitions in order to be eligible for a CI benefit. So, your underwriting will be different.

Family history, I think, is extremely important in the individual market. In the worksite market, I'd still like to see family history. Most people's interest in CI may be very much a function of what has gone on in their own families, such as family members who have had cancer or heart attacks. People, I think, are very much aware of the risks that they brought with them when they were born. So, I think family history is very important. It does affect rates.

So, we have all these issues. How will we price the product? I've tried to lay out what I think are all of the pricing assumptions that we, as actuaries, pay attention to, but I'll talk primarily about incidence rates and persistency. Page 7, slide 2, I think, shows the same basic thing that Susan alluded to. Critical illness incidence is higher than mortality, in some cases more than three to four times. That ratio increases with age up until the 50s. The ratio starts to level off and then still comes back down, but it's virtually higher at all ages except for males under age 30.

Where will you get your incidence rates? In the United States, CI is still a very new product, so the insured experience is scanty, at best. I think it's developing. There are a few carriers who have developed some credible blocks or blocks that are at least starting to be credible, at least for early durations. So, we frequently refer to general population statistics. For cancer, there's a wealth of very rich data from Surveillance, Epidemiology and End Results (SEER). It's available on the Web site. It's very extensive. It breaks things down by age, sex and type of cancer, and it's very rich. Cancer is typically the most frequent of the covered conditions in terms of incidence rates, and I think there's a lot of good data. Obviously, you need to make adjustments to it for the minor cancers, the carcinoma in situs. You'll try to weed out that, but I think the data in there is very good and allows you to do a lot of modifications to it. It also allows you to track trends, which I think is very important when you're looking at cancer and heart attacks. I'll talk a little bit more about trends in just a minute.

Data is available from other countries. While the product is relatively new in the United States, it's been around in South Africa since the early '80s, Marius Barnard being the first person to develop the product there. So, there is experience from South Africa. There is experience from Australia, Southeast Asia and the U.K. There's Canadian experience. I wouldn't necessarily use that experience by itself, but I think that in the absence of a lot of insured population experience here, it's worthwhile to look at that. The incidence rates do tend to vary quite significantly on the basic conditions from country to country, so you need to use a lot of judgment in how you'll apply that data in developing the incidence rates for your own product in the United States.

Back on our own general population statistics—I apologize for skipping around here—there's also some good data. The SEER data is the richest for cancer. There's also data available from the American Heart Association for heart attacks and stroke. There's data from the United Network for Organ Sharing (UNOS). That's available on a Web site.

Let's touch on trends. This is a health product. One of the things that I'm always concerned about with a health product is that, as opposed to mortality, for which you see a lot of improvements, there may be a tendency toward morbidity deterioration. With a product like this, there's an effort toward reducing heart attacks and cancer, but there's also an effort toward detecting things earlier. There's a risk that technology will allow us to detect things earlier. That will affect our claim cost. I think a good example of this is when they came up with a PSA test for prostate cancer a few years ago, you had a huge spike in your incidence rates at about five years earlier, on average, than the previous claims had been incurred. For those of you in the life business, if everybody were dying five years earlier on average than you expected, that would be catastrophic, and you do have some of the same risks, I think, associated with CI.

Obviously you need to make decisions about the degree and length of underwriting selection—particularly if you get into high face amounts. There's also the risk of anti-selection even at the low face amounts. Obviously you don't have to incur the ultimate cost of death in order to collect the benefit. There was a story about an individual a number of years ago in Europe who had a CI policy with a fairly high face amount benefit and noticed that the definition didn't provide any medical necessity. It provided benefit for coronary bypass, and he found a doctor who was willing to cut him open just to collect this benefit. I wouldn't be willing to do that, but there are some awfully strange people out there.

Let me briefly go through persistency, which typically varies by marketing method. Individual will have much higher persistency. Worksite will have lower persistency, particularly in the earlier durations. It will vary by issue age and duration. And persistency will be impacted by a number of your product features. If you have a return-of-premium feature, I think that will enhance persistency. Multiple payouts will enhance persistency. As for benefit reductions, I don't know if our business has

been around long enough to figure out what happens when policyholders reach age 65 or 70 and their benefits reduce in half, but that may increase lapse rates. I'm not sure. As I indicated, high early lapse rates in the worksite market can lead to a problem recovering your acquisition costs, but the low ultimate lapse rates will have some impact on your morbidity costs. I think it's important to do a lot of sensitivity testing around your persistency.

In conclusion, because there are so many unknowns about this product at this point in time, I recommend that we do a lot of experience monitoring. You do it early. You do it often. A lot of that requires that you be very explicit about what your expectations are, particularly for the early durations, and try to catch onto things that you missed and make adjustments. As I indicated earlier on, I think it's very important that you have a proper alignment of your product, your marketing and your underwriting. You don't want to try to force a square peg into a round hole. You do too much damage to both the product and the marketing—and to the underwriting, for that matter—if you're trying to do the wrong thing in the wrong market. The bottom line is that you're trying to get a balance of affordability, appeal (to both the consumer and the distribution), and obviously, profitability because we want the product to be around for a long time.

MS. MARCIA C. JOHNSON: Susan and I both have been on a mission, me actually longer than Susan. I've been fortunate enough to be involved in this mission for eight years. Sometimes I don't think I should brag about that because people told me a long time ago that you can tell the real pioneers. They have arrows in their backs. If I turned around, I've probably got about 500 arrows in my back over these eight years from what we've tried to accomplish in the CI marketplace here in the United States, but I've been very fortunate along the way.

I became very close friends with Dr. Marius Barnard and his family. I've traveled the world with him and have studied the world market, and there's good news and bad news. The good news is it's been around in the world market for 20 years, as you all know. Susan and I have both been talking about it, me for eight years and her for five years. I can remember meeting at an SOA meeting probably about five years ago, and Susan's right. There was probably about half the number of people in the room, and we spent the entire time saying what CI insurance is. It is a lump sum benefit paid upon diagnosis of one of 14 to 18 covered conditions, and the whole session was based on: "What is CI?"

Before I get started today, I want to say I do believe in all entities in the U.S. market—the worksite, the group and the individual market. Susan asked me to address the individual marketplace specifically because it's the part that we've ignored in the U.S. market, and it's also where we see the highest premium opportunity and the highest opportunity in general to rally traditional agents around the product outside of the worksite and the group markets. I did want to address that today, but keep in mind that I'm very supportive of all entities. Also, I think the challenge that we have in the U.S. market is that we have studied the

experience in these other countries for 20 years, and we have lost the simplicity of the fact that it is a lump sum benefit paid upon diagnosis. We're making it way too complex, even before it gets into the U.S. market. So, with that being said, let me move forward with my presentation.

Let's get back to some basics. What is at risk when suffering a critical illness? First of all, your health is. There's not a person in this room who doesn't understand the impact of what's going on in our health insurance benefits and the things that are not paid for under your current health plans, and that changes every day. I challenge any of you to discount the fact that we are gradually moving toward a defined contribution health plan world. The more money you have and the more you're willing to participate, the better the health care you'll be able to obtain. Medical technology continues to improve, and it gives us more hope than we've ever had before. But that comes with a price, which comes out of your pocketbook or, depending on your income level, your health actually suffers because you can't get that treatment.

I had a friend who had surgery four weeks ago. She had a tumor. Apparently there's some experimental shot that would shrink the tumor prior to the surgery, and if the shot were successful, she could do laparoscopic surgery rather than being sliced open. But the problem was, she had to pay for the shot, which was $500. Her insurance wouldn't cover it because it was not 100 percent guaranteed to shrink the tumor. So, she paid the $500 for the shot. It did shrink the tumor, and she was able to have the surgery laparoscopically. That's a very small example of what we're dealing with and what the price is all about.

People don't understand the total impact on finances, not only in the small worksite market, but also in the corporate business world. Obviously if you're out of work, you don’t have the earnings that you had before. Without money, you have to go back to work. Going back to work when you're not healthy continues to cause your health to decline. So, you're just on a treadmill.

Let's look at the impact on your business. Critical illness impact to a key employee is every bit as devastating, if not more so, than a death because that employee is still there, but they're not there. A lot of times you can't replace that person. Let's assume it's your business partner, and you don't have means with which to buy that business partner out. They're continuing to suffer with cancer and go through treatment, but they're not at work every day participating. So, the need to the business is there.

We've moved into a perception that critical illness is really a health problem and therefore, it can be paid for with health insurance or we can do the health supplements. In reality, health insurance only covers your direct cost, and the things that cause bankruptcy are all those indirect costs. There's a perception that critical illness is similar to long-term disability, thus DI will cover it. I don't know too many of my friends who have suffered a critical illness and have been declared

permanently disabled or even partially disabled. Even if they were, is there anybody in this room, even though we consider ourselves to be successful professionals, who could live off two-thirds of your income starting tomorrow and not change your lifestyle? I know I couldn't do it without making some substantial lifestyle changes.

I'd like to do just a quick little review of how we've moved down the path. We created life insurance eons ago because we needed a benefit that paid for dying but not the consequences of surviving. We created health insurance to pay for the consequences of an illness but not for surviving that illness. We created disability income to provide income on a short term while you're disabled, not the consequences of living with that illness. We created long-term-care insurance to pay for being permanently incapacitated from a critical illness for which you have to be confined to a nursing home, not the consequences of the fact that you will recover.

CI insurance is the only product that we are currently working on today that pays for the consequences, not the event. If you don't get anything out of that today, please let that sink in. We're looking at what the consequences of all those events are, and that's survival. Today, most of you are aware that CI insurance sales here in the United States are in the worksite market. That's accomplished through direct mail, print, referrals and existing book of business. That's also true in the group market. Traditional worksite is an enrollment issue versus an individual sale. I think that probably the reason it's had the success is because the exposure's already there. A lot of your group and your worksite salespeople are in front of these clients, and it's very easy to talk about an additional supplemental benefit. My hat is off to the worksite salespeople because they've done a good job of at least getting market awareness with their clients.

You know how on an airplane, everybody does that sneaky little glance over at your computer or whatever you're working on? I never had anyone ask me, when they would see something on my screen about split dollar or estate planning, "Hey, tell me about that." But ever since I started working in CI, anything I have out, either on my computer or in the way of marketing materials, the person sitting next to me on the plane has always asked, "What is that?"

I had the same experience yesterday with a gentleman who actually is in real estate investing. He buys real estate investments in foreign countries for a company he has here in the United States and was telling me all about his company, and he asked, "What do you do? Why are you coming to New York?" I mentioned that I was coming here to try to persuade a group of actuaries in the insurance community of the real need to develop more products in the individual CI insurance market. Normally, anybody sitting next to me on a plane would always ask, "What's CI insurance?" This gentleman, without hesitation, said, "Oh, that's that supplemental policy like AFLAC sells." For the first time, I had somebody next to me that sort of got it, CI insurance. I said, "No, it's not exactly that, but you're on the right track."

So, let's just focus a minute on reality. Here are two statistics that I use repeatedly to talk to the estate planning upper-end market agents. There are 70 million people alive today in the United States who have survived cancer, heart attack or stroke. The probability of incurring a critical illness before age 65 is nearly four times as great as the chance of dying from any cause. So, let's think about that a minute. If I have a four times greater probability of incurring a critical illness before age 65, which are my income-earning years, what are we really talking about? We're talking about income that provides financial well being for clients, that pays the mortgage, that does college funding, that funds retirement savings and that protects your business, which also means you have to do it with more than $50,000.

Everything you just heard were all the reasons we sell life insurance, but I challenge you by asking, if you have a four times greater chance of a critical illness before 65, does life insurance satisfy those needs? And the answer is no. Lifestyle protection is what we need in income-producing years, and insureds cannot protect their current lifestyles with a DI policy. They cannot protect their lifestyle with a worksite product. It's a great start, but the real product is in the fully underwritten individual marketplace. We've never shied away from a market before, and we don't need to shy away from it now.

I'll give you some realistic case studies. So, take your actuarial pricing hats off that Susan and John have had you put on, and put a marketing hat on here so you can think about this from a realistic standpoint. This actually came from an Australian magazine. If you departed, would your business go under? On the headstone, it says: In loving memory of Sam Jones, his office, the warehouse, 14 jobs, $500,000 goodwill, the family home, both company cars, the kids' school and next year's holiday ball. Change that a minute, though, and say, "If you became critically ill, would your business go under?" And the answer could possibly be yes, but then you can change things on the headstone. He's still alive. He still has expenses, so now the problem gets worse. So, for a business owner, particularly for an independent businessman, his health is very important to keeping that business going, as well as a key employer or partner. What about the old buy-sell agreements that we worked so hard on in life insurance? If you're four times more likely to have a critical illness, then that buy-sell agreement on death only protects you for a real small risk.

I've defined what I call the entrepreneur business owner market in the individual market as an individually fully underwritten policy used in key man insurance, debt protection, buy-sell agreements or for business continuation purposes. A typical face amount in this would exceed $1 million. Let's quantify this a little bit. According to the 2000 U.S. Census, there were 8.6 million Americans who were self-employed. If we as an industry had a product to sell, and we only penetrated that market by 1 percent with an average face amount of $1 million, that alone would provide us the opportunity of $1 billion annually in premium. Now that's 1 percent of just that one market.

On this case study, let's assume Mr. Key Executive is part owner and is 50 years old. He founded the company and is a 50 percent shareholder. The company's now valued at $5 million, and an investor group owns 50 percent of that. He wants to maintain the primary corporate relationships, but if he became ill, critically ill, he wants to ensure that he receives the value of his shares. He's not dead. His corporation wishes to create sufficient liquidity to replace him as CEO if he had a serious heart attack or cancer or stroke and was unable to come back and run the business. So, they purchased a $2.5 million policy to refund the purchase of his shares. We purchase $500,000 as a key management replacement to replace him with the company, and we purchase $500,000 to make up the shortfall in the market value of his business. Therefore, that creates a CI need of $3.5 million. I don't think you can argue with those facts behind where that sale is, but we're a long way from getting to that $3.5 million.

Let's take that down a notch and look at Middle America. I don't guess that you really have to be Middle America to be living from paycheck to paycheck. You just saw the statistics—52 percent of us do that. We have very limited savings and very heavy debt. There's starting to be a new trend in the stay-home spouse, not necessarily the female over the male, but one-income families are becoming more popular now while children are younger. Gradually we're all having to elect high deductibles on our health insurance, just to make it affordable. We've defined the middle market to be a need for an individual fully underwritten policy for people who make $75,000 to $150,000 annually. An average face amount policy would be around $300,000. To quantify that, the census in 2000 said there were 40 million households whose incomes were between $75,000 and $150,000, and if we did a 1 percent penetration into that market with an average face amount of $300,000, we would provide a premium opportunity to a carrier of $1.3 billion, just on that 1 percent of the middle income marketplace.

This is your home mortgage, your education funding, your retirement planning—all that true middle market income that a lot of us work in every day. I have a small case study here involving a 40-year-old male who is married with two children. His current annual salary is $100,000. We expect that salary to grow 3 percent annually during his earning years, and he has a company-provided retirement plan with an annual benefit of 1 percent of his final compensation. He owns a home with an outstanding mortgage of $125,000. We'd like to develop a plan to provide liquidity in the event that he incurs a critical illness. We want to fund his supplemental medical expenses. We want to pay off his mortgage, and we want to provide replacement income for 10 years.

A lot of people said our numbers were inflated because we looked at someone becoming ill and then being incapacitated from that point forward. This is saying we just give this guy 10 years of protecting his income, and I'll be happy to share the figures with you. We also actually decreased his income needs, assuming that after about five years, if he had survived to that point, that he would be able to go back to work. This solution alone just for a typical Middle American with $150,000

medical expenses, $125,000 of mortgage, and $319,581 of the after-tax present value of 10 years of his income stream created a CI need of $594,581. That's Middle America.

Last, but not least, let's consider the deferred compensation market. When we first introduced the product with Canada Life, we had a lot of people say, "If you're talking about income-producing years, that's where I like to protect my key people into established savings for deferred comp plans. If they develop cancer and never come back, then we just basically diminish that type of plan." What if we could take that same philosophy and have it fit into the deferred compensation market? So, we've tried to quantify what that is.

We're taking a typical case study of a very successful executive who wanted to set up a deferred compensation plan. He's 45, with three children. I have the figures. I can share this with any of you, too, if you need me to send them to you. He has a current salary of $300,000. We're giving him a $75,000 bonus and a growth of 5 percent. Those of you who have worked in the deferred comp market understand how all that works. It's tied in with years of service. Basically, what we come up with is that if the company purchased a CI policy to cover estimated medical expenses of $500,000 over his lifetime, replace his income at 75 percent of pre-retirement earnings for five years, 50 percent for the next five, and 25 percent thereafter, at a net present value of 5 percent, that's $3,281,250, or with the $500,000 medical reimbursement, a $3,781,000 need of CI policy.

This is a little bit of a challenge to all of you. First of all, let me read something to you. There's a Web site called criticalillnesslearning.com. It's published in Canada and has a lot of good sales ideas. In an issue last spring—I got on their Web site, and I was reading, looking for some good sales ideas—I came across a big article that was talking about the Canadian market and the world market, and then it said, "And then there's the U.S. marketplace, and the U.S. marketplace for critical illness is still a dog's breakfast of confusion. Most companies are still reviewing the lint in their navels and still having discussions about reinventing the wheel and its purpose. As long-term-care sales lagged last year, there's no defined leadership or champion for CI in the U.S. It would be un-American for these people to look north of its border to see how successful marketing works in the CI marketplace." And it goes on and on. While you want to laugh about that, I took that seriously because somebody told me that anytime you look at something that's negative, there's always a grain of truth. And there is a grain of truth in that.

National Underwriter, in the September 27 issue, said, "What doesn't kill you can make you poorer. Poor health may not kill you, but it could bankrupt you, and baby boomers who are small business owners may particularly be vulnerable to the certified financial planner who is also a health-care specialist." Basically, it ranked the top 10 states in which residents of those states did not have health care, and it goes hand in hand with bankruptcies. Every state that had the highest shortage of health-care coverage for residents of that state also had the highest bankruptcy

rate. Our industry's been built, especially actuaries and the reinsurance community, on finding a financial need for insurance, whether it was health insurance, life insurance or long-term-care insurance. People need to transfer risk where they cannot afford the impact or loss. I think what I've just showed you clearly is that individuals, even from the smallest level up, cannot survive the impact of a loss, of suffering a critical illness.

It's up to us, because we are in the risk business, to figure out a way to price that product, all the way up to the individual fully underwritten market, instead of sitting back and saying, "It's too risky. It's too costly." What you're all about is figuring out a way to take that risk and pool it in such a way as to make it affordable so that we marketing types can go out there, sell it and make a lot of money. We're doing our part. We're getting the market awareness out there. Now you do your part and create these products for us. It's your mission. It's your responsibility.

MS. KIMBALL: That was very informative. We have some time for questions.

MS. DIANA S. WRIGHT: I'm with Fidelity Security Life Insurance Company. The issues you've addressed this morning have been very enlightening. They focus primarily on the direct aspect of this type of product. Many companies also need the distribution of risk, and could you address the reinsurance availabilities on this product?

MR. CATHCART: Gen Re is active in the market. Gen Re has been active in CI since its inception, actually when it was Cologne Re and started in South Africa. Marius Barnard started the product with a company called Crusader Life. Cologne Re was behind them at that point in time. We are trying to help develop the market. Obviously, we want to do it on a very rational basis, and I would be more than happy to talk to you about it. There are other reinsurers, but I'm really not in a position to address where they are.

MR. RUSSELL A. OSBORN: I'm with Nationwide Financial. Could you speak to the tax implications of this, both in terms of inside buildup and the taxability of the benefits?

MS. JOHNSON: First of all, there is no non-forfeiture value. At this point, a stand-alone CI policy is classified as health insurance and therefore, it's treated under the health insurance regulations. So, to the extent that you pay your own premiums, then the benefit is tax-free to the beneficiary. If it's inside a corporate-type plan and the corporation funded it, then the benefit would be taxable when it's paid out.

For the rider attached to a life insurance policy, up until a year ago or at least nine months ago, there was a question mark. It's a real gray area as to whether it was treated as health insurance or life insurance. It would be treated as an accelerated benefit rider, but if it exceeded a certain percentage of the death benefit, it would be taxable. There was a private letter ruling that came out last spring that basically

said that long-term-care riders and CI riders attached to a life insurance policy are not taxable. They're treated as health. So, the rider portion, as it participates in the life insurance plan, should also be tax-free.

FROM THE FLOOR: A criticism of specified illnesses is that if they're not included in the contract, there's no coverage, even though the financial implications would be exactly the same, the consequences that were described earlier. For example, an exotic condition, such as Guillain-Barré syndrome, might not be covered, but it would effectively work almost like a stroke, with exactly the same financial consequences. How do you respond to that criticism from a marketing perspective?

MS. JOHNSON: I'll draw on my expert teacher, Dr. Marius Barnard. Anytime he got that question all over the world, he'd always say, "Sir, we'd like to cover ingrown toenails, too, but it makes it way too expensive for the rest of the population to buy this product." Our response, too, is that we'd like to cover everything, and as we get a larger pool base and get more product into the market and can drive the cost down, we'll continue to add benefits. But initially, we need to come out with the most critical conditions to try to cover the masses, and then we'll add those benefits as pricing and volume of business allows us to.

MS. KIMBALL: I agree. Also, there were some companies talking about covering situations where your medical expenses go up over a certain amount, then benefits would kick in. There are issues there with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) because you're no longer just covering specified diseases. You're throwing in a general catch-all. It's different than the true CI product, and basically you can't cover everything. I think if you at least cover the cancer, heart attack and stroke, you're covering 80 percent of the claims, and that's really going to cover the majority of the population.

MS. JOHNSON: But on the marketing side, to respond to what Susan just said, since your big three account for 80 percent of your claims, to me the rest of those are also very critical conditions. As you guys figure out how to price it better for us so we can sell it, adding those benefits will not increase the cost substantially. My goal from a marketing standpoint is that anything that you have in the way of a true critical illness—I think that's the part you have to make sure it's defined as—that impacts your income potential and your earnings and takes you out of the work force is covered under a policy. I don't think it should have 100 different conditions or even 40, such as in the Pacific Rim countries, but I think we do need to work toward covering as many of those critical conditions as possible.

MR. CATHCART: As Marcia just alluded to, in other countries a lot of the competition is a function of how many conditions you cover. In the United States it's still a very new product, and I'm a little bit concerned that if we try to start adding too much to it, we'll kill it before it gets off the ground. I think it's important to try to keep the product simple and affordable for now. Obviously there are some

very serious conditions that would add very little cost if you included them, and the market may eventually go that way. It probably will, but I think that we need to look at it carefully. You also need to consider not only the additional cost in terms of incidence, but also the additional cost in terms of underwriting for those conditions, too, because your underwriting will be targeted toward whatever conditions are covered.

MS. ANNMARIE T. BROWNMILLER: I'm with Reinsurance Services of Princeton. I have a question about regulatory issues, particularly state filing requirements, and restrictions on the voluntary and group side with respect to underwriting in particular. I don't know if you have any experience with that.

MS. KIMBALL: Help me out with the underwriting restrictions. I'm not sure what you mean.

MS. BROWNMILLER: I had an instance in which I was making a filing of an actuarial memorandum in Florida, a group vehicle, and was told by the consultant who was assisting us with the filing that Florida would disallow any underwriting questions—any age rating or tobacco/non-tobacco.

MS. KIMBALL: Any underwriting questions at all?

MS. BROWNMILLER: They were viewing it as discriminatory in some respects. I believe they would not even allow us to make an age distinction on the rating, nor a smoking distinction. So, my possible solution was just a staggered benefit by age or staggering into 100 percent of the benefit.

MS. KIMBALL: I've been more involved in the past in doing individual and worksite products, and that issue didn't come up in Florida.

MS. BROWNMILLER: Right. We wanted to keep to a group filing, but we were running into some trouble.

MS. KIMBALL: Met is filing a group product, but we have not done Florida yet, so I'm sorry that I don't have that experience.

Sometimes you need to argue back to the state. Even if it's not in their statutes, it doesn't always work. They have a lot of desk-drawer rules on CI as well, whether it's no waiting period or mammograms in California. There are definitely a lot of challenges with filing this. That's a new one that I hadn't run into, but we'll be looking forward to that when we do Florida.

MR. FRANK S. AUSTIN: I'm from AIG. One thing I notice is that you keep defining this as a lump sum at the event of a critical illness. Has anybody even looked at any kind of benefit designs in which there's some part that's paid as a life annuity

or at least a 10-year certain, something of that nature? Have you seen any of that design any place?

MS. JOHNSON: I've seen that put on the drawing board. Not that I wouldn't be receptive to anything like that, but being the marketing person that I am, I don't want to see this product confused with an indemnity-based health insurance program, a DI program. The beauty of the product is it's a lump sum benefit that gives you as the sick person the ability to use that money for anything. I think you lose that when you put it in the form of something like annuity payments or indemnity payments or tie it to some type of DI that pays "if you're alive three months from now, we'll pay you $500 more."

The beauty of this is that I can buy a motorized wheelchair because I have multiple sclerosis. If I want to take my family around the world because I know I'll go through cancer treatment, I can do that. I'd hate to see our industry, before we even get it started in the United States, moving away from the true beauty of the product, which is a lump sum benefit that gives that person control of whatever they need it for.

MR. JEFF ROBINSON: In the worksite marketing and the group area, what are the portability provisions, particularly if it's a guarantee renewable contract or even if it's not? If an employee leaves, can he take the policy with him?

MR. CATHCART: Yes, an individual product is still an individual product. All you're doing is changing the premium collection from payroll deduction to individual pay.

MR. ROBINSON: What about in a group situation in which it would be one-year renewable? Is there a convertibility feature?

MS. KIMBALL: Often there is, yes.

MS. JOHNSON: It depends on the carrier. The experience we've had is that you were allowed to convert to an individual policy in those small face amounts.

MR. ROBINSON: What's the persistency like when it goes from worksite marketing to individually billed? Is that lousy?

MS. JOHNSON: I don't think we have enough experience, really, to tell that.

MR. CATHCART: I think you can look at other companies that are active with other products in the worksite, and one of the primary drivers of lapse rates is people leaving their place of employment.

MR. ROBINSON: I have another question, and this may not be the venue for it, but what about valuation considerations in the guaranteed renewable individual market? Regarding active lives, is it tabular or is it judgment or what is it?

MR. CATHCART: You do need active life reserves. You do have a fairly steep claim cost curve. There are no published tables, so it's a lot of judgment. You'll typically use your pricing claim cost, your pricing incidence, with some appropriate load. For statutory, you obviously have interest and lapse rates for health products. So, that's already addressed. The main thing that's not addressed is: What incidence rates do you use?

MR. ROBINSON: If there are no published tables, what do you use for pricing?

MR. CATHCART: Basically, you go back to using population statistics, and you'll use a fair amount of judgment.

MR. ROBINSON: And claim reserves would be judgment?

MR. CATHCART: Basically, you might have an incurred but not reported (IBNR), but it's a full payment upon the incidence. You won't have a tail.

MR. ROBINSON: But what about if they could come back? Isn't it a situation where some companies say if there's a recurrence, you can come back? I worked with one company, and they had a long tail on cancer policies, and I don't think this is much different.

MR. CATHCART: That's a good question. Obviously, if you're going to have a multiple occurrence, do you adjust your active life reserves for those policies because there will be a second occurrence after the first, or do you just build that into the active life reserves like any health product in which you can have multiple benefits?

MR. ROBINSON: What's the difference between this and dread disease? In the old days, departments did not like dread disease policies because they figured that people had other insurance needs that were greater, and people didn't understand dread disease. Nobody calls it dread disease anymore. New York won't allow it. I don't know what they do with CI, but they wouldn't allow a dread disease policy.

MR. CATHCART: I think the main distinction is that this is a lump-sum benefit versus the AFLAC-type cancer product, which was basically a dread disease, and it's an indemnity product.

MS. KIMBALL: And New York is approving CI, but they do have a lot of things that you have to change in the product.

MS. SUSAN I. ALLEN: I'm with United American Insurance. I've been asked to look at CI in the direct response market, where obviously they need to look at simplified issue versus fully underwritten. I just wondered if you had some brief comments on how the CI product might work in a direct response market.

MS. KIMBALL: I think it's a little iffier because you're cutting back on underwriting. You'll probably get more of the risks that say, "My parents had this, and my sister had that, so I'd better get this insurance." I would think there'd be more anti-selection, and you'll have to price for that. Obviously, you don't want to price so much that you only get the bad risks, so you have to weigh that. I haven't heard of anyone really jumping into that market yet. I think it will be challenging.

MS. JOHNSON: We had a couple of agents who tried that, but we did not have the simplified issue product to go with it. Since then, there have been products that have been adjusted from the worksite to that, either guaranteed issue or simplified issue, with a few of the health questions. Face amounts were very small. The response was very good. We even had somebody who did a Web marketing kind of thing, but people saw health insurance, lump sum benefit. They responded. The people who purchased it were negligible because they didn't understand. At the time there was just not enough market awareness. They read the brochure, and then when it came time to write the check, they didn't after they read enough to say, "I don't know if this really does the job." So, the sales for it were way too premature.

I definitely think there is a market for that, particularly with a lot of the credit card companies. We worked on a project with Citibank Worldwide for a while to do a lot of direct marketing with them in the international market. I think as the product matures, then that would certainly be something in the future. But I'm not sure market awareness is quite there yet.

MR. JACK GREENBERG: I'm from Columbia Mutual Life. I have a question regarding the various state insurance departments that have limited the types of benefits that are allowed on the products. I know New York is one of those states. Not that I expect you to put yourselves in the minds of the regulators, but do you have any clue as to why some of the departments are limiting these benefits?

MS. KIMBALL: I'm not sure exactly that I've seen that the benefits are limited. In New York, for example, they make you cover all forms of the disease, so all forms of cancer, You even have to cover skin cancer or other things that aren't that serious. So, they actually make us cover more than what we were going to cover. Ours is a fairly simple, straightforward product, so we didn't hear that they came back and said, "You can't cover certain illnesses."

MR. GREENBERG: Our product specifically has a blindness and a paralysis benefit, and New York State, at least in its published regulations, does not allow those benefits. They may allow it as an exception, for which we are still in the process. There are a couple of other states—I forget which ones offhand—that had similar objections to those particular benefits. I know that you've talked before about the possibility of expanding the product, but at least in certain states it does appear that there are some restrictions on whether or not you're allowed to expand.

MS. KIMBALL: That's good information to know, so thank you for sharing that. I can't really imagine why the states would have a concern about that, unless they just don't want it to grow to a huge number of covered conditions.

FROM THE FLOOR: Too difficult to define the illness?

MR. GREENBERG: Blindness is pretty straightforward.

MS. KIMBALL: Now, when you get to Alzheimer's and MS, it's a little more challenging. They might not think it's truly critical.