BROKER WORLD

Critical Illness Insurance—The Journey

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PhD, is president of US Living Benefits (USLB) and founder of the National Association for Critical Illness Insurance (NACII). He is a national speaker on topics and trends related to critical illness insurance (CII). Pisetsky has developed innovative CII products, as well as marketing support, sales training and continuing education courses. His expertise, focus and dedication have established him as one of the foremost leaders in the CII market.

Pisetsky started his career in the teaching profession in 1970. During his career in education, he held positions as teacher, curriculum specialist, and consultant for gifted and talented student programs. He joined CIGNA Corporation in 1982 as manager of human resources. While at CIGNA, he joined the accident and health reinsurance division, where he worked for 12 years, eventually being promoted to vice president.

Pisetsky left CIGNA in 1995 to start his first company, Insurance Consultative Services, and in 1997 started USLB, a company specializing in CII. USLB is a consulting and marketing company as well as an independent marketing organization representing major CII carriers for individual, worksite and group sales. USLB is currently focused on developing individual CII sales.

USLB clients include brokers, niche marketing organizations and associations.

Pisetsky holds a BS in business, a Master's in education, and a PhD from the University of Connecticut.

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Historically, the idea of critical illness insurance (CII) began with the first heart transplant in 1967, performed in South Africa by Dr. Christian Barnard and assisted by his brother, Dr. Marius Barnard. It was Marius who postulated that at the time of a calamitous medical event—e.g., heart attack, stroke, cancer, organ transplant—usually there was a corresponding financial burden that could go beyond medical insurance coverage.

Marius Barnard worked with a South African insurance company, Crusader Life, to introduce the first policy in 1983. CII is different from most insurance products in that it pays a lump sum upon a diagnosis. These monies can be used for out-of-pocket medical expenses, medical insurance deductibles, mortgage payments, children's education, etc. Marius is known as the founder of CII and went on to assist in the development of products throughout the world, including Australia, the United Kingdom, Japan and Canada.

CII was introduced in the United States in the early 1990s. Carriers included heart, stroke, and life-threatening cancer as the core conditions, since they comprised 80 percent of critical illness conditions. In addition, U.S. carriers included in their products other specified diseases, such as organ transplant, paralysis and coma.

My personal involvement with CII began seventeen years ago. My partner, an actuary, developed a CII pricing model based on U.S. incidence rates, rather than interpolating European incidence rates. Initially, our company was utilized as the CII pricing back room for a large international reinsurer. We believed that given the great success of CII globally, U.S. carriers would be highly receptive to launching this innovative product.

At the onset, carriers did not embrace CII. In fact, the first carrier I met labeled the product as "a gimmicky cancer product." Another stated that CII would not work in the United States because "we're a highly litigious society." In addition, carriers believed that CII would only work in countries with socialized medicine.

U.S. carriers assumed one of two roles: market leaders or market followers. Initially, Canada Life and smaller companies such as Oxford Life, National Travelers and Colorado Bankers introduced CII products. Subsequently, larger carriers such as Unum, Colonial, Trustmark, Mutual of Omaha and Metropolitan entered the market, giving additional credibility to the product.

In 2000 I realized that for this market to continue to grow in the United States, we needed to establish a national trade association. I spent two years contacting CII carriers and reinsurers, urging them to provide the necessary seed money to launch such an association. Ten carriers/reinsurers eventually contributed. In 2003 we launched the National Association of Critical Illness Insurance (NACII) and held our first national meeting in Atlanta, with Dr. Marius Barnard honoring us with his presence as our keynote speaker.

NACII's mission states:

"To forge an active and effective alliance among stakeholders in the critical illness arena. The association's programs are designed to educate and disseminate information in an effort to synchronize development of insurer programs, insurance department regulation, and to enhance the public's and producers' knowledge of the growing need for critical illness insurance."

From 2003 through 2007 we continued to see new carriers enter this market, along with increasing sales. The U.S. market focused on the worksite. Policies sold for smaller amounts of coverage, usually less than $25,000, using simplified underwriting.

In 2007 Harvard University conducted a national study on bankruptcy. Results indicated that medical debtors who declared bankruptcy had debts of more than $5,000, on average. Typical medical debtors are described as well-educated home owners who hold middle class occupations. A significant finding from the study indicated that three quarters of these debtors had medical insurance. This study substantiated that a cash infusion from a CII policy could help prevent bankruptcy.

During this same period a catalyst for CII sales in the United States was the move by employers to consumer-driven health care plan designs. Higher deductible health plans along with health savings accounts were introduced. Health care financial decisions were beginning to shift away from the employer and to the employee. Since CII paid upon diagnosis, these policies could be used to fill gaps in medical coverage deductibles.

The "Great Recession" that began in 2007 brought a period of high volatility in the mortgage and equity markets. If a person experienced a medical calamity, there was a strong likelihood that access to cash could be a problem. Tapping into assets (e.g., home equity, stocks and retirement accounts) in a down market only exacerbated the financial problems.

Even though employment decreased during the recession, we continued to see new carriers entering the market, as well as increases in sales in worksite and group. The main CII drivers were changes in health care coverage as well as a need for liquidity.

> *"These policies can be used to complement individual disability and long term care coverage."*

With the passage of the Affordable Care Act (ACA) in 2010, we would see the beginning of a sea change in health care for individuals and groups. The law provided for the implementation of market reform, establishment of exchanges and the expansion of Medicaid eligibility. The goal of the ACA was to increase the quality and affordability of health insurance.

In 2013, ACA implementation provided individuals access to health coverage through state and federal exchanges. Typically, exchanges offered three or four plan designs—e.g., bronze, silver, gold and platinum—each having deductibles for an individual or family. Along with public exchanges we are now seeing a movement by employers to have employees select health care benefits utilizing private exchanges. Employers are moving from a defined benefit health care model to a defined contribution model. No longer is comprehensive employer-paid health insurance a given. Instead, employers are allocating a certain dollar amount for employees to utilize in purchasing medical and voluntary coverages.

It's worth noting that in 2014 two studies contributed to increasing awareness of the need for CII. MetLife's study estimated that the out-of-pocket costs associated with a critical illness can be more than $14,000. The study also noted that the lost income from a critical illness can top $50,000. Since these costs are not included in medical coverage, CII can provide the employee/individual with a cash infusion, filling coverage gaps.

The second study, "Americans and Their Money," was conducted by *Money Magazine* in January 2014. *Money* surveyed adults to determine how they felt about their finances. One of the survey questions asked, "Could you handle an unexpected $10,000 expense?" Sixty-six percent of the participants with household income of less than $100,000 and 38 percent with household income of more than $100,000 indicated that this would be a hardship, as most likely they would need to borrow money or tap into equities or their retirement accounts. Gaining access to cash for a critical illness may pose a significant financial hurdle.

Today in the U.S. market, CII continues to gain traction. There are more than 50 carriers in the market, generating more than $300 million of new annualized premium. Most of the sales continue to be in the worksite and group channels, with the average size policy being less than $25,000. Simplified and guaranteed issue underwriting is the norm for this market.

Furthermore, individual CII is beginning to become a stakeholder in the U.S. market. These policies may have issue ages from 18-99, with coverage amounts up to $500,000, with full underwriting. Individual policies may be targeted to professionals, business owners and those who are self-employed. In addition, these policies can be used to complement individual disability and long term care coverage.

During my 17 years working with this product, despite all the economic and legislative changes that have taken place, CII continues to grow as a mainstream, voluntary product, providing financial cushions in the event of catastrophic illnesses. Now more than ever, CII is the right product for the right time.

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