

ASISA STANDARD ON DISCLOSURES FOR CRITICAL ILLNESS PRODUCTS

1. Introduction

There has been growing concern over the past few years from policyholders, intermediaries and the Long Term Insurance Ombudsman that the Critical Illness (also known as Dread Disease or Severe Illness) product is becoming more complex and difficult to understand. It is important to note that many insurance products are intricate as they have to cater for various complex, uncertain and unpredictable events.

Critical Illness products are designed to pay out a benefit when a policyholder has a serious illness or suffers a traumatic event which results in financial difficulty. In order for the product to be practical and affordable, the illness or trauma needs to be sufficiently serious before the sum insured is paid out. If this were not the case there would be many payouts which would make the product expensive and therefore less accessible.

To ensure that consistent and objective claims decisions can be made, the definitions used to determine whether a policyholder qualifies for a payout need to be sufficiently detailed. Some level of medical terminology is required which can be difficult for many people to understand.

It is acknowledged that this is a necessarily complex product but the absence of standard industry definitions and the fact that insurers' definitions are significantly different from one another, further increases the complexity and uncertainty.

There is a global precedent of deriving standardised definitions and this has been done in the UK, Singapore and Malaysia. Other countries like China and South Korea are also in the process of standardising definitions. Hence ASISA had a reasonable amount of information to work with and could learn from some of the mistakes made in previous processes. Unlike the products sold in the aforementioned countries, some of the Critical Illness products sold in South Africa are severity-based and this makes it more difficult to standardise the definitions.

It needs to be strongly emphasised that standardised definitions do not necessarily mean simpler definitions. In many instances the definitions are more detailed, but they will lead to only one set of definitions for the policyholder to understand and decisions will be more consistent.

As a result of all the points raised above, the former Life Offices Association (LOA), whose members are now part of ASISA, set up the SCIDEP committee (Standardised Critical Illness Definitions Project) to derive a set of standard industry definitions. The committee consisted of doctors, underwriters and actuaries from various insurance and reinsurance companies.

Due to the fact that many Critical Illness claims triggers are medically based, the industry often comes into conflict with medical practitioners whose definition of when someone had a heart attack, for

example, was not the same as the insurance definition. Independently of the process to standardise the definitions, the insurance doctors and the clinical doctors had various workshops to come up with definitions that were suitable to both parties. Much of this work was incorporated in the SCIDEP project.

2. Scope and implementation

The new ASISA definitions apply to any product that uses any of the four core diseases (listed in Section 3 below) except:

- functional impairment products
- disability products
- products that only cover a part of a disease, for example a breast cancer product.

For clarity the following products are examples of those that need to use the ASISA definitions:

- Traditional individual life Critical Illness products
- Group Critical Illness products
- Critical Illness with and without severity based definitions
- Life cover with acceleration on the diagnosis of a Critical Illness
- Waiver of premium on Critical Illness cover
- Mortgage protection Critical Illness cover.

It is not necessary for insurers to change their product philosophy or marketing material. The purpose of the standardised definitions is that it will provide some “underpin” to the product therefore providing policyholders and intermediaries with;

- (a) the comfort that they can get their claim assessed on industry approved definitions, and
- (b) that they can get a better understanding of when and at what level different insurers will pay out.

The process does not attempt to stifle competition as insurers are not restricted in terms of the number of diseases covered, the percentage paid out, the number of payouts that can be made, or the rates that they charge. It is possible for insurers to keep all of their documentation the same, except for the fact that they must state (as set out below) using the disclosure grid what percentage they would pay out under the ASISA definitions. Hence insurers merely need to map their current payouts to the ASISA definitions and provide the disclosure grid.

The definitions do not have to be applied retrospectively and are only applicable to Critical Illness policies entered into after the implementation date of 1 September 2009.

- From 1 September 2009 all life offices, who are ASISA members, must apply the definitions and disclosures;

- The disclosure grid must be placed on members’ websites and included in all new marketing material on critical illness products issued after 1 September 2009;
- By no later than 1 April 2010, members must include the disclosure grid in their quotes and/or contracts. The ASISA critical illness definitions and the layman’s definitions may be included, but don’t have to be.

3. Application

3.1 The standard definitions apply to the following four “core” diseases, which make up between 70% and 90% of all Critical Illness claims:

- Heart attack
- Cancer
- Stroke
- Coronary Artery By-pass Graft (CABG).

The definitions cover four tiers, A, B, C, and D, with A being the most severe and D being the least severe.

The definitions for “Heart attack” and “Stroke” allow for several functional parameter definitions to allow for insurers’ existing product philosophies.

3.2 Although the sixteen definitions (four diseases with four severities) are standardised, the percentage payout for each of the definitions is up to the discretion of each insurance company. Therefore an insurer can pay between 0% and 100% for each severity of each disease. An insurer cannot pay a lower percentage for a more severe definition, although they can pay the same percentage. (One exception to this point is that this only applies to payouts on medical definitions and insurers are allowed to boost the payout for non-medical conditions.)

3.3 The disclosure grid must include the following content:

Critical Illness Benefit Disclosure Grid as measured against ASISA critical illness definitions

	Severity Level (the percentage payout for each level must be shown)			
Event	A	B Moderate	C	D Almost full

	Most severe	impairment	Mild impairment	recovery
Heart attack				
Coronary Artery By-pass Graft (CABG)				
Stroke				
Cancer				

An insurer can add more severity conditions, either more severe than A or less severe than D, but again the more severe conditions must pay more than or the same percentage payout as A, and the less severe conditions must pay out less than or the same percentage payout as D.

Any product that offers one or more of the four core diseases must use at least one of the four severity definitions. This also applies to single disease products, for example “cancer products”. For the purpose of clarity, if an insurer selects one of the lower severity levels as their starting point then all of the more severe levels must also be covered at least at the same percentage as the chosen severity definition.

It should be noted that the definition of each severity level of each of the 4 conditions has been given a specific heading or title. It is advisable that companies start using these more descriptive event headings or titles. The more descriptive titles will be more transparent to the consumer, illustrating that not all events diagnosed as such are necessarily covered, but only events meeting certain defined criteria. For example the title “heart attack” as used in current contracts creates the impression that any heart attack is covered. The new titles clearly demonstrate the difference in severity:

Level A: Heart attack with severe permanent impairment in function

Level B: Heart attack with mild permanent impairment in function

Level C: Moderate heart attack of specified severity

Level D: Mild heart attack of specified severity

3.4 Although it would be ideal for all insurers to use the standardised definitions in their quotations and contracts, there are some practical restrictions that may make this difficult to implement. Hence insurers only, at a minimum, have to state that they will honour claims according to the ASISA critical illness definitions, for at least one severity level of each of the four core diseases that they cover. This means that no insurer can have 0% cover for all four severity levels of any given condition. If a claim is declined on the insurer’s definition, the policyholder will have the right to insist that it is also assessed according to the ASISA definitions. This will only apply to

those levels of definitions where the insurer has indicated a certain percentage benefit. In cases where 0% cover has been indicated, the ASISA definitions will of course not be enforceable.

This implies that if an insurer has indicated 0% cover on the disclosure grid for one or more of the severity levels of the said 4 conditions, that insurer will be entitled to use its own contractual definition for the events in question. However, if a percentage cover has been indicated on the disclosure grid for a specific severity level of a specific condition, then the insurer will be obliged to assess claims for that event on the basis of the ASISA definition.

The quotation and/or contract must state what percentages the insurer will pay out for using the disclosure grid by 1 April 2010. This will enable policyholders to easily compare the benefits of different insurance companies.

4. ASISA critical illness definitions

The standard definitions for the four “core” diseases are set out below. A layman’s definition for each disease has also been included to assist with understanding, but these do not form part of the definitions.

Stroke- ASISA critical illness definition

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 hours, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist.

For the above definition, the following are not covered:

- Transient ischaemic attack;
- Vascular disease affecting the eye or optic nerve;
- Migraine and vestibular disorders;
- Traumatic injury to brain tissue or blood vessels.

Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months.

Level A: Stroke with severe impairment

Needs constant assistance, as measured by:

- the inability to do 3 or more basic ADL’s, or
- a Whole Person Impairment (WPI) of greater than 35%.

Level B: Stroke with moderate impairment

Cannot function independently, as measured by:

- the inability to do 6 or more advanced ADL’s, or
- a WPI of 21% to 35%.

Level C: Stroke with mild impairment

Can function independently, but has impairment as measured by:

- the inability to do 3 or more advanced ADL's, or
- a WPI of 11% to 20%.

Level D: Stroke with almost full recovery

Almost full recovery, with little residual symptoms or signs, as measured by:

- the ability to do all basic and advanced ADL's, or
- a WPI of 10% or less.

WPI figures are calculated as per the American Medical Association Guides to the Evaluation of Permanent Impairment 6th edition.

Basic activities of Daily Living

- Bowel status
- Bladder status
- Grooming
- Toileting
- Feeding
- Transfers from chair to bed
- Indoor mobility
- Dressing
- Stairs
- Bathing

Advanced activities of Daily Living

- Driving a car
- Medical care: prepares and takes correct medications
- Money management
- Communicative activities: use of phone, writing checks, writing letters
- Shopping: lifting or carrying groceries

- Food preparation
- Housework
- Community ambulation with or without assistive device, but not requiring a mobility device
- Moderate activities: moving table, pushing vacuum cleaner, bowling, golf
- Vigorous activities: running, heavy lifting, sports

Notes:

- TIA exclusion included only for clarity.
- Trauma is not covered in this instance as a “stroke” is meant to be as a result of an illness not a head injury. Companies could always add in a major head trauma product or include traumatic injury as a competitive advantage.

Stroke - Layman’s Definition

A stroke occurs when the blood supply to a portion of the brain is obstructed and this part of the brain tissue dies. It can also happen when there is bleeding into the brain tissue due to a weakening or abnormality of the blood vessel wall. A common cause of the rupture of a brain blood vessel is longstanding uncontrolled high blood pressure.

The result of a stroke is usually paralysis of an arm and leg, sometimes with one half of the face affected as well. In some cases people also lose their ability to speak. The paralysis can recover to varying degrees. Some recover fully, whereas others may retain permanent weakness of a limb(s).

A Transient Ischaemic Attack (TIA) occurs when the blood supply is momentarily interrupted, but restored before any permanent damage can occur. It usually results in one or more of the following symptoms:

- a loss of sensation
- dizziness
- lameness of a limb
- loss of speech

which only occur for a few minutes to hours and recovery is quick and spontaneous.

CABG - ASISA critical illness definition

The undergoing of surgery to correct the narrowing of, or blockage to, one or more coronary artery(ies) by means of a by-pass graft.

Level A

The undergoing of surgery to correct the narrowing of, or blockage to, three or more coronary arteries by means of a by-pass graft.

Level B

The undergoing of surgery to correct the narrowing of, or blockage to, two coronary arteries by means of a by-pass graft.

Level C

The undergoing of surgery to correct the narrowing of, or blockage to, the left main or proximal left anterior descending coronary artery by means of a by-pass graft.

Level D

The undergoing of surgery to correct the narrowing of, or blockage to, any one coronary artery by means of a by-pass graft.

CABG - Layman's definition

Coronary artery bypass graft surgery, also called heart bypass or bypass surgery, is a surgical procedure performed to relieve chest pain and reduce the risk of death from heart disease.

Arteries or veins from elsewhere in the patient's body (most commonly the leg) are joined to the coronary arteries of the heart to bypass the narrowings of the affected or diseased arteries. This improves the blood supply and circulation to the heart muscle. The terms "single bypass", "double bypass", "triple bypass", "quadruple bypass" and "quintuple bypass" refer to the number of coronary arteries bypassed in the procedure

This surgery is usually performed with the heart stopped necessitating the usage of highly specialised theatre equipment to keep the heart and the lungs working during the course of the operation.

Heart Attack - ASISA critical illness definition

Level A: Heart attack with severe permanent impairment in function

A Heart attack that meets the criteria as defined under Level C, with permanent impairment in one or more of the following functional criteria, as measured 6 weeks post-infarction:

Criterion	Value
NYHA classification	Class 4
METS	1 or less
LVEF	< 30%
LVEDD	> 72
Ultrasound FS in %	< 16%

Notes:

1. If more than one functional criterion is impaired, but their values do not conform to one severity level (for example one impaired value is Level A and another Level B), the final severity level should be determined by giving preference to the more objective criteria, that is in the following order:
 1. LVEF
 2. LVEDD
 3. Ultrasound FS
 4. METS
 5. NYHA

Level B: Heart attack with mild permanent impairment in function

A heart attack that meets the criteria as defined under Level C, with permanent impairment in one or more of the following functional criteria, as measured 6 weeks post-infarction:

Criterion	Value
NYHA classification	Class 2 or 3
METS	2-7
LVEF	30%-50%
LVEDD	59-72
Ultrasound FS in %	16%-25%

Level C: Moderate heart attack of specified severity

This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by two of the following three criteria:

1. Compatible clinical symptoms
2. Characteristic ECG changes, which can be either of the following:
 - a. New pathological Q-waves as defined in Annexure A, or
 - b. ST-segment and T-wave changes indicative of myocardial injury, as defined in Annexure A, but only when accompanied by raised cardiac markers as described hereafter.
3. Raised cardiac markers:
 - Trop T > 1,0 ng/ml or Trop I > 0,5 ng/ml, or
 - Raised CK-MB mass
 - More than 2 times normal values in acute presentation phase, or
 - More than 4 times normal values post-intervention.
 - Total CPK elevation of more than 2x normal values, with at least 6% being CK-MB.

Level D: Mild heart attack of specified severity

This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by all three of the following criteria:

1. Compatible clinical symptoms and
2. Characteristic ECG changes, e.g. ST-segment and T-wave changes indicative of myocardial ischaemia or myocardial infarction, and
3. Raised cardiac markers:
 - Trop T > 0,5 ng/ml or Trop I > 0,25 ng/ml, or
 - Raised CK-MB mass
 - Up to 2 times normal values in acute presentation phase, or
 - Up to 4 times normal values post-intervention.
 - Total CPK elevation of up to 2x normal values, with at least 6% being CK-MB.

The evidence must show a definite acute myocardial infarction. Other acute coronary syndromes, including but not limited to angina, are not covered by this definition.

Definitions of ECG changes

a. ECG changes indicative of Myocardial Ischaemia that may progress to Myocardial Infarction:

- Patients with ST-segment elevation:
 - New or presumed new ST segment elevation at the J point in two or more contiguous leads with the cut-off points greater than or equal to 0.2mV in leads V1, V2, or V3, and greater than or equal to 0.1mV in other leads.
 - Contiguity in the frontal plane is defined by the lead sequence AVL, I and II, AVF, III. (Ref. 1)
- Patients without ST-segment elevation:
 - ST-segment depression of at least 0.1 mV;
 - T-wave abnormalities only. (Ref. 1)

b. Definition of new pathological Q-waves:

- Any new Q-wave in leads V1 through V3;
- A Q-wave greater than or equal to 40 ms (0.04s) in leads I, II, AVL, AVF, V4, V5 or V6;
- The Q-wave changes must be present in any two contiguous leads, and be greater than or equal to 1mm in depth. (Ref. 1);
- Appearance of new complete bundle branch block.

Heart attack - Layman's description

Four levels of severity of heart attacks are defined:

- Level D is the mildest and Level A the most severe.
- In both levels C and D the patient recovers fully and the heart function returns to normal.
- In levels A and B, more permanent damage has resulted, which means the heart function is less than 100% after recovery.
- The effect of the heart attack on heart function should be measured 6 weeks after the heart attack.

Level A: Heart attack severe impairment in function

These are heart attacks where a significant proportion of the heart muscle was damaged. The same tests are used to measure the damage as under Level B but the results would show a more serious level of impaired function.

This person will have difficulty coping with normal activities of daily living, and will most likely not be able to work.

Level B: Heart attack with mild permanent impairment in function.

This is usually a heart attack that does not recover 100% of normal function. The degree of permanent damage can be measured by a heart sonar, an exercise tolerance test or a measurement of physical abilities. These measurements should be performed 6 weeks after the heart attack.

A person with this level of heart damage should still be able to manage normal daily activities and even his/her occupation, if the occupation does not involve strenuous physical work. However, this person's insurability will be adversely affected, and the future risk for a repeat cardiac event is high. Significant life-style adaptation and risk factor modification are indicated.

Level C: Moderate heart attack of specified severity

In this case damage to the heart muscle is more than in Level D. In some cases a cardiologist will intervene early and reverse the potential damage. This intervention may include administration of drugs to dissolve the blood clot in the coronary artery(ies), balloon stretching of the coronary artery, with or without a stent.

Because the clinical methods of diagnosing this level of heart attack are unambiguous, only two of the three criteria are required:

- Typical chest pain or other symptoms typically associated with a heart attack.
- Certain defined ECG changes. At this level the changes are more marked and more specific to a heart attack.
- Elevated blood test results greater than required for Level D.

Level D: Mild heart attack with full recovery

This is a heart attack where the ECG changes and blood test results are mildly abnormal. Therefore, all three criteria are required, i.e.

- Typical chest pain or other symptoms associated with a heart attack, and
- Certain defined ECG changes, and
- An elevation in certain blood test results.

Cancer - ASISA critical illness definition

A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

The following conditions are excluded from this definition:

- All cancers in situ and all pre-malignant conditions.
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
- All skin cancers, other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).

Severity levels for cancers are done according to the general classification of cancers into four stages. However, prostate cancer, leukaemia and lymphoma do not conform to this general classification. Therefore additional tiering levels are proposed for these cancers.

Tiering of all Cancers except prostate, leukemia and lymphoma

The levels are correlated to the general classification used by the American Joint Committee for Cancer for the type of cancer involved:

- Level A - Stage 4 cancer
- Level B - Stage 3 cancer
- Level C - Stage 2 cancer
- Level D - Stage 1 cancer

Tiering of prostate cancer		
Stage 1	T1a, N0, M0, G1	Excluded
Stage 2	T1a, N0, M0, G2 to G4	Excluded
	T1b, T1c, N0, M0 any G	Excluded
	T2, N0, M0 any G	Level D
Stage 3	T3, N0, M0 any G	Level C
Stage 4	T4, N0, M0 any G	Level B
	Any T, N1 - 3, M0 any G	Level A
	Any T any N M1 any G	

Tiering of leukemia and lymphoma

Level A:

This benefit will pay for any one of the following diagnoses:

- Acute Myeloid Leukaemia;
- Chronic Lymphocytic Leukaemia, stage III or IV on the Rai classification;
- Chronic Myeloid Leukaemia (requiring bone marrow transplant);
- Acute Lymphocytic Leukaemia (adults);
- Hodgkins/Non Hodgkins lymphoma Stage IV on Ann Arbor classification system;
- Multiple Myeloma Stage III on the Durie-Salmon Scale.

Level B:

This benefit will pay for the following diagnoses:

- Hodgkins and Non Hodgkins lymphoma Stage III on Ann Arbor classification system

Level C:

This benefit will pay for any one of the following diagnoses:

- Chronic Lymphocytic Leukaemia (stage II on the Rai classification);
- Acute Lymphocytic Leukaemia (children);
- Chronic Myeloid Leukaemia (no bone marrow transplantation);
- Hodgkins/Non Hodgkins lymphoma Stage II on Ann Arbor classification system;
- Multiple myeloma Stage I and II on the Durie-Salmon scale.

Level D:

This benefit will pay for any one of the following:

- Chronic Lymphocytic Leukaemia (Stage 0 or 1);
- Hairy cell leukaemia;
- Hodgkins/Non Hodgkins lymphoma Stage 1 on Ann Arbor classification.

Notes:

- Histological confirmation is required
- There is no requirement to undergo treatment.
- Prophylactic mastectomy for carcinoma in situ will not qualify under this definition as the cancer is not invasive.

- The committee tried to avoid using classification or staging terms, but could not in the case of prostate. This was because staging definitions may change over time and are complex for the consumer.
- The committee decided not to exclude any HIV related cancers.

Cancer - Layman's description

Cancer is an uncontrolled growth that spreads into the normal tissue surrounding the organ where the cancer originates. The diagnosis must be supported by tests where a pathologist confirms the presence of cancer cells using a microscope. Some cancers have been specifically excluded because:

- The long term outcome is good and the effect on quality of life is minimal;
- Treatment is neither expensive nor extensive;

There are specific exclusions to this definition that include;

- Cancerous cells that have not invaded the surrounding or underlying tissue;
- Early cancer of the prostate gland and breast;
- All cancers of the skin except cancerous moles that have invaded underlying tissue.

Staging of cancer

As a general rule there are four stages of cancer. Stage 1 cancer is defined by an invasive cancer confined to the tissue or organ of origin. Stage 2 cancer is defined by the involvement of adjacent structures or organs. Stage 3 cancer involves spreading to regional lymph nodes. Stage 4 cancer is characterized by distant metastasis.

However, each type of cancer is staged specifically by the American joint Committee for cancer (AJCC). This staging is based on the outcome of the specific cancer and does not always follow the general rule as stated above. In order to standardise staging we have used the AJCC system which is the same system used in clinical practice by specialists who treat cancer.

Annexure: Detail on Cancer Staging

The classification systems referred to in the annexure is for reference purposes only and will not form part of the definitions.

Lymphoma

HODGKIN'S and NON-HODGKIN'S LYMPHOMA

2. Ann Arbor Staging System

Stage I	<p>The lymphoma is in a lymph node or nodes in only 1 region</p> <p>The lymphoma is found only in 1 area of a single organ outside of the lymphatic system(E)</p>
Stage II	<p>The lymphoma is in 2 or more groups of lymph nodes on the same side of the diaphragm</p> <p>The lymphoma extends locally from a single group of lymph nodes into a nearby organ (IIE). It may also affect other groups of lymph nodes on the same side of the diaphragm.</p>
Stage III	<p>The lymphoma is found in lymph node areas on both sides of the diaphragm</p> <p>The lymphoma may also have extended into an area or organ next t the lymph nodes(IIIE), into the spleen(IIIS), or both(IIE,S)</p>
Stage IV	<p>The lymphoma has spread outside of the lymph system into an organ that is not right next to an involved node</p> <p>The lymphoma has spread to the bone marrow, liver, brain or spinal cord or the pleura</p>

The letter A or B denotes the absence or presence of symptoms.

3. Burkitt's lymphoma staging

A - Single solitary extra-abdominal site

AR - Intra-abdominal, more than 90% tumour resected

B - Multiple extra abdominal tumours

C - Intra abdominal tumour

D - Intra-abdominal plus one or more extra-abdominal sites

4. Leukaemia

Binet Clinical staging system

Stage	Clinical features at diagnosis	Median survival (years)
A	Lymphocytosis and <3 areas of palpable lymph nodes	>7
B	Lymphocytosis and >3 areas of palpable lymph nodes	<5
C	Same as stage B with anaemia or thrombocytopenia	<2

5. Durie-Salmon classification

Stage	Durie-Salmon Criteria	ISS Criteria	Prognosis
I	All of the following		
	<ul style="list-style-type: none"> - Hemoglobin value > 10g/dL - Serum calcium value normal or ≤ 12 mg/dL - Bone x-ray, normal bone 	β_2 -M < 3.5 mg/dL and albumin ≥ 3.5 g/dL	60 months Median Survival

	structure (scale 0) or solitary bone plasmacytoma only - Low M - component production rate - IgG value <5 g/dL; IgA value <3 g/dL Bence Jones protein < 4 g/24 h		
II *	Neither stage I or III	Neither stage I nor stage III	41 months
III	On or more of the following: - Haemoglobin value <8.5 g/dL - Serum calcium value >12 mg/dL - Advanced lytic bone lesions (scale 3) - High M-component production rate IgG value >7 g/dL; IgA value >5 g/dL - Bence Jones Protein >12g/24 h	β_2 -M \geq 5.5 mg/dL	23 months

Durie-Salmon sub classification (either A or B)

A: Relatively normal renal function (serum creatinine value <2.0 mg/dL (<177 μ mol/l))

B: Abnormal renal function (serum creatinine value \geq 2.0 mg/dL (> 177 μ mol/l) - Stage B worse outcome

* Stage II = β_2 -M <3.5 or β_2 -M 3.5 - 5.5 mg/dL, and albumin <3.5 g/dL

Stage	Clinical features at diagnosis	Median survival (years)
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A	Lymphocytosis and <3 areas of palpable lymph nodes	>7
B	Lymphocytosis and >3 areas of palpable lymph nodes	<5
C	Same as stage B with anaemia or thrombocytopenia	<2