Underwriting manuals and tele-interviewing

A number of underwriters may have been told early on in their careers that doctors, not underwriters, make the diagnosis. They do this based on a clinical assessment of their patients and have all the facts at their disposal. After all, they have had the chance to talk to their patient and ask pertinent questions, something the underwriter could only do through a paper application form. Or so it was a few years ago.

Consider also what happens in the Emergency Room. Faced with a patient with a history of stomach pain the admissions nurse will have to determine the seriousness of the condition, whether investigations are required and whether the person might benefit from immediate treatment and if so what that might be? ER staff must triage the urgent from the important from the insignificant in terms of treatment and investigations required based on their experience.

So making a medical diagnosis is really a kind of detective work and is similar to the way underwriters need to assess applicants and their risk of significant disease.

Underwriting manuals were traditionally created to fulfil a number of objectives which might include:

- Educating the underwriter on a medical subject
- Providing a method of classifying risks – separating the good risk from the not so good
- Providing rating guidance for the medical impairment

In the majority of cases, the rating guidance was based on a medical problem being given a diagnosis by a physician. But in recent years the game has changed and it continues to change.

One driver has been critical illness where the underwriter may be faced with a history of vague neurological symptoms which may or may not have been investigated. Often no definite diagnosis has been made and the physician has decided on a course of 'watchful waiting'. This to the uninitiated appears very similar to 'do nothing'.

Faced with this incomplete information the underwriter has to make a call on whether the symptoms are significant, especially if the policy covers multiple sclerosis. Over the last few years reinsurance audits have highlighted that sometimes underwriters fail to appreciate the real significance and so, possibly with some anti selection by the applicant, so early claims have been incurred.

Despite this very few underwriting manuals provide the underwriter with guidance on how to deal with an applicant who has a history of neurological symptoms with no diagnosis.

Now, with the increasing use of tele-interviews the situation is going to be exacerbated because the applicant may disclose a history where they do not have a precise diagnosis. The use of appropriate drill down questions and a skilled tele-interviewer can extract a lot of good quality information about the applicant. But there may not be a diagnosis.

So what does the underwriter do? Write to the attending physician to obtain a diagnosis (which in some cases won't exist)? Not only will this mean that some of the benefits of tele-interviewing (saving time and costs) may be wasted but does the underwriter have the skills to make the right decision? Are they able to use their skill and judgement to determine the significance of the applicant's history? Where do they turn for help? Their medical director? Their underwriting manual?

In our view some of the drill down questioning now being used has now moved into territory not covered by the reinsurers' underwriting manuals. Underwriters are now getting information that is simply not covered in the manual. The wrong sorts of information in fact. But what does the underwriter do? We can see problems where cases are subsequently audited by the reinsurer and the direct office underwriter's decision is criticised. The underwriter may try to defend themselves by stating 'well that's not in the manual'.

Direct offices will be keen to accept applicants on the information from the tele-interview. Otherwise the tele-interview may be a waste of time and money and there will be internal pressure to do away with a report from the physician.

On the other hand the reinsurer is concerned about their mortality experience and turnaround times are less important. Do the reinsurers need to provide guidance that stipulates when additional evidence should be sought or what is the minimum evidence that is required and the source?

So where do we go from here?

In short the underwriter will need some assistance:

- To make a good quality, informed decision
- To understand the red flags that should mean further evidence is required
- To understand the significance of certain investigation s that may mean the significance of the history is less (or more sinister) than first thought
- To ensure a consistent approach

Either direct companies will have to develop their own internal guidelines or they will need to look to their reinsurers to update their own manuals. Tele-interviewing is a big step forward in terms of gaining increased and better quality information but this also means it is different to what the underwriter has had before.

Underwriters may also need to be 'retrained' to underwrite with different information. Care is needed to balance the need to get additional information from a physician to corroborate the additional disclosures but at the same time using experience to judge when the applicant's story makes sense and nothing would be gained from a 'second opinion'.

From work we have recently been involved it is clear that the information underwriters are receiving is rapidly changing and that very few underwriting manuals have been updated to reflect this changing environment. This needs to change so that we can maximise the benefits of tele-interviewing.

Contact: gary@selectx.co.uk

© SelectX Ltd
July 2010