

# Major changes in screening protocols are necessary if life insurance

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## The Post-Millennial Metamor



### THE VENERABLE LIFE INSURANCE INDUSTRY AWOKE ONE MORNING

to find itself transformed into a financial services industry. Unfortunately, no one thought to tell those who stand astride the flow of new premium assuring that the ratio of actual-to-expected mortality remains far less than one. In other words, underwriting was—and to a great extent still is—out of step with the financial services concept.

This must change.

Today, life insurance CEOs have five major priorities interlaced with how risk selection is conducted:

- ▶ Reduce business acquisition costs;
- ▶ Shorten new-business cycle time;
- ▶ Accommodate alternative modes of distribution;
- ▶ Retain high-quality producers;
- ▶ Be customer-friendly.

In the area of business acquisition, there are two major new costs: commissions and underwriting. Suffice it to say the latter is more likely to be put under a microscope!

While the new business cycle (application-to-issue) time begins before underwriting takes place and goes on after the risk has been appraised, the primary determinant of its duration is inevitably the risk-appraisal process. Certain distribution domains (banks, work sites, and the Internet) have been particularly stymied by two colliding priorities: rapid issue to forestall steep drop-offs in placement rates and sufficient underwriting so that premiums are competitive.

Today's heavy-hitting agents and brokers will not abide mediocre support from underwriters. In a 2004 producer survey,

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is going to remain a player in the financial services revolution.

# phosis in Life Underwriting

LIMRA's Denise Marvel reported that service and support—actually, the lack thereof—together constituted the second leading reason agents and brokers changed carriers. Brokerage gurus Duwayne Kilbo and Paul Faletta didn't mince words on this matter, writing in the November 2006 *Broker World* that with only a few exceptions “overall life insurance new business service time is dreadful.”

If insurers hope to retain sales forces and recruit new agents at a time when their numbers are declining, they must do more than just offer lip service in the area of field support. The No.1 concern is getting policies underwritten and issued as rapidly and efficiently as possible.

It's unlikely that the man on the street's perception of financial services encompasses running like a pet gerbil on a treadmill or being exposed to carcinogenic radiation by virtue of a mandatory chest X-ray. Nevertheless, one or both of these expensive, time-consuming, and customer-unfriendly requirements are often imposed on persons age 55 or older who apply for seven-figure amounts of coverage.

Why is it that when the need to change the underwriting process to satisfy the mandates of senior management is so obvious, the pace of change has been so slow? After extensive dialogue with chief underwriting officers from a crosssection of insurers, we would argue that five factors contribute to this dilemma:

- 1.** It's in the nature of underwriting, like many other industry domains, to move (sometimes agonizingly) slowly in this regard. Hence, there is a pervasive culture at loggerheads with change.
- 2.** Chief underwriting officers, who would drive these changes, already have far too much on their plates.
- 3.** While information technology is intrinsic to change, all too often those championing needed changes find the phrase “IT support” nothing short of oxymoronic.
- 4.** Reinsurers are largely ambivalent to the agendas of direct writers. Their concern is mortality results and, more to the point, short-term mortality fluctuations. It's understandable, therefore, that they might vex over unproven changes in underwriting protocols. Yet there's also often an expectation by direct writers that reinsurers will invest adequate resources to fully apprehend the value of looming enhancements.
- 5.** Certain vested interests may be disposed to use their clout to obfuscate and inhibit progress. These elements must be seen for what they are so that their impact is both marginalized and contained.

## The Transformational Platform

In 2007, a major transforming event took place in the United Kingdom. In a 12-page manifesto, the Association of British Insurers (ABI) bestowed its imprimatur upon a new business process known as teleunderwriting. In so doing, it designated this radical approach to risk management as being harmonious with the interests of Her Majesty's subjects.

Despite the fact that the first official blessing of teleunderwriting occurred in the U.K., this process has its roots on our side of the pond. The earliest experiments in teleunderwriting began here in the mid- to late 1980s. As of last year, 75 percent of over 130 American life insurers responding to an industry survey affirmed their use of teleunderwriting for at least part of their business.

Historically, insurers gathered risk-related information from insurance applicants in one of three ways:

- ▶ Nonmedically—an agent asks the questions and records the answers;
- ▶ Paramedically—a nonphysician medical person (today, primarily phlebotomists) asks and records the answers in concert with performing a handful of physical measurements and collecting body fluids;
- ▶ Medically—a physician asks and records the answers as part of an ostensible medical examination.

With teleunderwriting, the gathering of risk information is accomplished with a telephone interview, conducted with the proposed insured by either a home-office caller or an interviewer employed by a service firm.

Insurers have turned to teleunderwriting as the preferred approach because of the greater quantity and superior quality of risk-related information that it provides. This information is what largely determines whether or not an underwriter needs to get medical records (attending physicians' statements). While medical records are essential with impairments such as cancer and heart disease, they are increasingly costly and the primary driver of protracted delays in underwriting. They are also likely, in coming years, to lack key content because of changes in privacy laws, etc. It's easy to see why insurers want to pare back their use of physicians' reports.

Teleinterviews, with their drill-down questioning of all "yes" answers to risk-related questions, offer far more information for underwriter consideration than do traditional applications (despite the impossibly small boxes in which such information must be crammed). As a result, properly conducted teleunderwriting has sharply reduced the ordering of physicians' statements and cut the cycle time for new business.

"Nationwide reduced its time service from 42 days to about 19.8 days," reported Mary Holloway, vice president of Nationwide Life, to *LOMA Resource* magazine in 2005.

Any carrier's failure to realize a major drop-off in the ordering of physicians' statements through the use of teleunderwriting can be tied to one or more of four underlying problems:

- ▶ Its drill-down questionnaires are woefully inadequate;
- ▶ Its interviewers aren't performing in an effective manner;
- ▶ Veteran underwriters are stubbornly clinging to obsolete beliefs as to when a physicians' statement is needed;
- ▶ There's a disconnect between interview content and action guidelines in the underwriting manual, forcing underwriters to order a physicians' statement for clarification.

All these problems can be remedied. Therefore, the bottom line is that teleunderwriting:

- ▶ Lowers new business acquisition costs, because one physicians' statement requires the same outlay as four teleinterviews;
- ▶ Reduces cycle time, because the average physicians' statement takes at least 12 to 14 working days to procure, whereas 90 percent or more of teleinterviews are completed in three days or less;
- ▶ Facilitates nontraditional modes of distribution;
- ▶ Lessens the burden imposed on agents and brokers by insurance home offices, allowing them more time to sell;
- ▶ Negates legal encumbrances related to agents and brokers taking risk histories themselves;
- ▶ Provides applicants unprecedented direct input on their insurability;
- ▶ Eliminates 90 percent of nondisclosure, which is an incidental byproduct of nonmedical, paramedical, and medical exam history-taking.

## Core Tools in a Teleunderwriting Environment

The advantages of teleunderwriting are maximized when insurers also embrace other risk appraisal assets that emphasize rapid turnaround. American underwriters enjoy a huge advantage over international peers in that they have access to three screening assets unique to this country: Medical Information Bureau (MIB) codes, motor vehicle reports, and pharmacy profiles.

The MIB needs no introduction here. It's been the cornerstone of thwarting antiselection for decades. Motor vehicle records are easily and quickly acquired from state insurance departments. Given the mortality consequences associated with drunk/drugged driving, as well as recent driving records awash in moving violations, etc., insurers have expanded their scrutiny of these records at all ages. In the same way, knowing what pharmaceuticals are being taken by proposed insureds tells the underwriter a great deal about the nature and extent of medical impairments. This is why there's inevitably a question about prescription medications on life insurance applications.

Prescription profiles derived from data sequestered by pharmacy benefit management firms can be obtained at a relatively low cost. Currently, a typical insurer can access these profiles on 70 percent or more of its applicants. Because of the wealth of salient information that they provide, their use has skyrocketed in the past several years. If, for instance, an applicant experiences sudden memory loss when asked about prescription drug use, the profile compensates for the amnesia (often, the medication not disclosed



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is the one of greatest relevance to insurability). With insurers granting preferred risk rates to applicants undergoing treatment for high blood pressure and elevated cholesterol, prescription profiles allow underwriters to pinpoint noncompliance, as manifested by failure to refill prescriptions at appropriate intervals. Similarly, dosing and the mode of delivery (oral, injected, transdermal, etc.) can be key factors in assessing medication-use implications. These facts are included in prescription profiles, along with contact information for the physician prescribing each drug.

MIB codes, motor vehicle reports, and prescription profiles are typically in the underwriter's hands even before teleinterviews are completed. Thus, when taken together with the bounty of information on a properly executed teleinterview, they allow the underwriter to make all but immediate insurability determinations on a substantial share of cases. This potent trio, used in context with teleinterviews, should be a boon to those in alternative distribution modes who have, until now, considered underwriting to be a four-letter word. This is also true for simplified-issue products, which are now triaged on the basis of a thin batch of so-called knockout questions.

### Relics, Survivors, and New Options

"Currently, life insurance company risk assessment protocols include cardiovascular tests that are expensive, time-consuming, and inconvenient for applicants," wrote Ross MacKenzie, a practicing physician, in a 2007 editorial that appeared in the *Journal of Insurance Medicine*.

The tests MacKenzie refers to are throwbacks to a bygone era when budgets and expectations accommodated expenditures, delays, and egregious impositions upon customers. Unfortunately, they continue to undermine our efforts to mesh risk appraisal with the financial services concept.

The three main culprits are chest X-rays, treadmill stress tests, and resting electrocardiograms (ECGs). The arguments for their demise are imposing. They are too expensive. They are

highly subjective and prone to inconsistencies in interpretation that incite counterproductive collisions with applicants' personal physicians. And except for ECGs, which can be administered by paramedics, their acquisition time is protracted and they impose unnecessary burdens on customers.

Consider these facts: According to the *Annals of Internal Medicine*, experts concluded in 1986 that chest X-rays were no longer appropriate for screening patients being admitted to hospitals. Yet in 2008, a significant minority of life insurers still require exposure to carcinogenic radiation—that is, chest X-rays—for larger policies at older ages. An expert panel of cardiologists determined in 1989 that treadmill stress testing wasn't justified for asymptomatic patients. This conclusion was reaffirmed at the Cleveland Clinic, whose cardiologists stated that "screening for (coronary artery disease) with exercise treadmill testing could not be considered a cost-effective strategy."

Nevertheless, in 2008, the substantial majority of life carriers continue to insist that applicants perform on treadmills to be eligible for large amounts of coverage.

Also in 1989, a review of 40 studies led Stanford investigators to argue that "the evidence does not support doing a screening ECG in men without evidence of cardiac disease..." This finding is buttressed by Harvard and University of California San Diego cardiologists, who wrote in the *Annals of Internal Medicine* that "...routine use of ECGs is warranted only in selected subsets of hospitalized patients..." Nevertheless, in 2008, nearly all life insurers required resting ECGs for potential insureds (a requirement that is triggered at younger ages and for lower amounts of insurance coverage than requirements for treadmill tests or chest X-rays).

To rid ourselves of these relics and costly physician examinations that have low marginal value, we need viable alternative screening tests that don't encumber the underwriting process. There are several screening tests that have been with us for years that continue to contribute sufficient payoffs without compro-

## The presence of one undesirable health habit means that others are highly likely as well.

missing our overarching priorities: paramedical exams, blood and urine profiles, and oral profile tests.

Until now, medical histories have been part of the paramedical process. This is no longer desirable because teleinterviews are far superior, and redundant history-taking is anathema to customers. Although the ideal configuration changes by age, the remaining components of the paramedical exam have important roles in risk assessment.

Blood and urine profiles provide so much protective value at age 40 and above that they are a mainstay of risk appraisal for these ages. Oral fluid screening has a niche with younger potential insureds. Carriers use these samples, primarily collected by agents, as an alternative to blood and urine. The argument for this is that mortality under age 40 is largely driven by trauma, not disease. All three oral fluid components have profound implications for non-disease-related deaths.

There are also two major innovations destined to make major contributions to life insurance risk management: specialized geriatric testing for cognitive dysfunction and physical frailty and a heterogeneous aggregation of blood tests that should eliminate any preference for ECGs, treadmill tests, and screening X-rays for cardiac-risk assessment.

Life underwriters borrowed cognitive and frailty screening practices from their peers in long-term care and then enhanced them for use in a life insurance context. With insurers offering coverage at age 80 and beyond and in consideration of the mortality implications of cognitive and physical function decline, these elements are vital to underwriters.

Where blood test screening is concerned, the hot new item is a test called NT-proBNP. No screening modality in underwriting history comes close to this marker for cardiac damage. A 2007 white paper reviewed nearly 300 studies constituting the world literature on NT-proBNP at that time and revealed the length and breadth of its value. Industry medical expert Dr. R. K. Illango put an exclamation point on this evidence with his 2007 article in the *Journal of Insurance Medicine*, which stated that "...this test will revolutionize how we screen for cardiac risks and if used appropriately save a lot of money."

There are several additional blood tests now under scrutiny that could combine with NT-proBNP as a screening protocol at ages 55 and older:

- ▶ Hemoglobin A1-c—a test used in assessing blood-sugar control in diabetics and recently shown to have great value in screening for cardiovascular disease.
- ▶ Cystatin C—an upgrade over existing kidney tests and a potential indicator of cognitive impairment and frailty.
- ▶ Hemoglobin—the test for anemia, a condition with dramatic, if

underappreciated, insurability implications for the elderly.

What makes this multitest protocol so alluring? It comes at a tiny fraction of the cost of the treadmill test (\$700) and chest X-ray (\$210). It can be done on a blood sample collected for the screening blood profile. It provides objective results for consistent decision-making. It isn't encumbered by the baggage (handling time, delayed analysis, customer inconvenience) that was inherent in the old tests.

### The Future

Researchers, trying to explain why some patients are compliant in taking prescribed drugs while others aren't, identified a phenomenon they call the "healthy adherer effect." The basic tenet of this effect is that prescription adherence is just one of a constellation of health habit practices that some embrace while others reject. The presence of one undesirable health habit means that others are highly likely as well.

Well supported by countless medical studies, the healthy adherer effect offers the intriguing option of including health habit questions in teleinterviews. These might include:

- ▶ Do you usually wear your seat belt when driving?
- ▶ On average, how many hours of sleep do you get per night?
- ▶ To women age 45 and older: Do you have an annual mammogram?
- ▶ To their male counterparts at age 55 and older: When was your last PSA test?

And so on...

We believe the questioning of health habits is both germane and appropriate in the context of teleunderwriting. As it happens, so do our colleagues in the U.K., who are already putting elements of this strategy to productive use. Quality teleunderwriting, using information from third-party databases, new bodily fluid tests, and continually evolving questions can allow underwriters to better align themselves with corporate goals without sacrificing underwriting quality. ●

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