An illustration of two men with large noses and exaggerated features. The man on the left is wearing a dark suit and is pointing towards a cake. The man on the right is wearing glasses and a brown jacket, holding a fork. They are both looking at a small, round cake with white frosting and strawberries on top, which sits on a white plate. The background is a light blue, textured surface.

Today's life insurance consumers expect fast, accurate, and uncomplicated underwriting turnaround. What they often get instead is the runaround. But now there are ways to speed up the process and keep the customers happy...

# Having Your Cake & Eating It

By Hank George

**N**ONTRADITIONAL (or, alternative) life insurance distribution systems find themselves in a quandary. They want to have their cake (rapid turnaround, from application to issue) and eat it acceptable mortality/morbidity experience; minimized antiselection).

Wishful thinking?

With traditional approaches to risk management, yes. But there may be a way to have acceptable turnaround and adequate underwriting to avoid undesirable outcomes. Let's begin by defining our terms.

Nontraditional distribution refers to insurance sales through banks, on the Internet, by telemarketing and direct mail, and at retail sites. For the most part, these are products sold without the services of an agent or broker. Thus, there's no one positioned between the carrier and the client to gather information, to dote over and, as needed, to assuage the prospective insured when the process of acquiring insurance seems onerous.

● *Unconventional Underwriting for Nontraditional Distribution*

There's a widely held (and, likely, accurate) perception that the success of nontraditional distribution depends, at least in part, on speeding up the often sluggish process that begins with the insurance application and ends with policy issue and delivery. These new insurance distribution channels can't accommodate protracted intervals. It's realistic to project that insurers will have a few days—not weeks or, sadly, months—to dissect and approve risks. Anything longer than that, on average, and the prospects for placing the coverage in force will be greatly compromised.

This context renders traditional risk management tools, such as medical examinations, inspection reports, electrocardiograms, and chest x-rays, all but useless. They're too slow, too cumbersome, and, one might add, way too expensive.

Even more disconcerting is the extent to which life underwriters traditionally depend on physicians' reports. Measured from request to receipt, they're the slowest of all underwriting resources. There's no way physicians' reports can serve as a core underwriting resource for nontraditional business (at least not until someone finds a way to speed up their acquisition process dramatically).

It's easy to see why nontraditional life insurance providers feel caught between the proverbial rock and a hard place. If they underwrite adequately, they'll see the rate of declined business skyrocket, undermining their efforts. Conversely, if they disdain sound underwriting, they're forced to either overprice their merchandise or run the gauntlet of adverse mortality. Either solution lays waste to their profitability.

The specter of antiselection hovers. If they unwittingly facilitate scenarios ripe for pillaging by those who have a "special need" for insurance, they'll pay dearly.

The history of life insurance is replete with sad tales of those who thought they could pare underwriting to bare bones, or even eliminate it completely, and still prosper. In the age of AIDS and the hepatitis C epidemic, antiselection is no laughing matter.

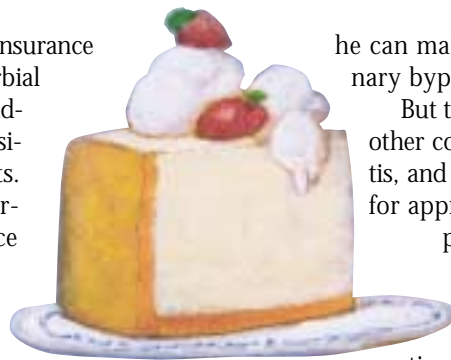
There is a solution. But to get to it requires a dramatic paradigm shift, one that may induce scary symptoms in those too wedded to the past. We have the means to accomplish sound underwriting, within the turnaround time constraints mandated by nontraditional distribution. That's to say, we can have our cake—and eat it—if we embrace a dynamic new way of assessing risk.

And there's a fringe benefit if we do. The new way is customer-friendly, a quality that hasn't always been part of what we have historically called "underwriting."

### The Primary Solution

In order to approve adequately underwritten life insurance applications—from application initiation to policy issue—in a median interval of 72 hours, the underwriter will largely need to abandon tools that are too slow. This means routine use of medical exams, most (but not all) medical tests, inspection reports, and physicians' reports.

Not every physician's report can be dispensed with, however. If a proposed insured has a history of cancer, for example, the underwriter must acquire key information from the physician to sufficiently ascertain the risk before



he can make an offer of insurance. Ditto for coronary bypasses.

But the same cannot be said quite so readily for other common impairments such as asthma, colitis, and even diabetes. There is dramatic potential for appraising such risks without routine use of physicians' reports.

How? By using faster information-gathering modalities.

In the case of diabetes, these modalities might consist of a detailed questionnaire probing the medical history plus a urine or oral fluid (saliva) laboratory profile. Such a combination could be gathered in a few days. Even if a blood profile is needed to assay diabetic markers, the use of a responsive collection service would allow most cases to be presented to the underwriter for a decision barely a week after the application is taken—a fraction of the time required if an underwriter holds out for a physician's report!

The anchor of this new paradigm will be a questionnaire, much like those gathered, currently by many companies, in a format some call a "telephone inspection report." This underwriter prefers the term personal history interview (PHI) because it better reflects the actual contents of such reports.

The PHI, conceived in the 1980s, began as a simple reprising of the application questions. Additional power was added through the collection of protective information; YES answers were amplified by drilling down the proposed insured with a handful of impairment-specific questions. The PHI continues to evolve with questioning of the proposed insured about a range of epidemiologically valid information related to health status, risk of disease and death—and, ultimately, insurability.

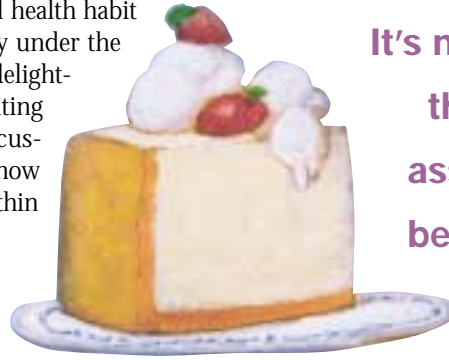
We've done this for years for tobacco use and the results have been gratifying. We succeeded in charging those who choose to increase their mortality risk by indulging in tobacco more for their insurance to cover that risk. And when we took the bold step to do this, those who previously had criticized underwriting as "unfair" came to applaud smoker/nonsmoker (more accurately, user/nonuser!) underwriting as just!

The next step in this process will be more dramatic. It will embrace a wide range of what one might call health habit issues. The factors we'll target will be largely under the control of our customers. (One of the more delightful effects of this new approach to underwriting will be higher approval ratings from our customers!) But the focus, for now, should be on how this will allow us to assess and price risks within the aforementioned 72-hour time constraint.

It's now an established fact that the mortality curve associated with alcoholic beverage consumption is U-shaped. That is to say, mortality is higher in teetotalers than in temperate (one or two drinks per day) drinkers. This is most strikingly evident with heart disease, but it's also been shown to extend to all-cause mortality.

More recently, investigators have looked at specific alcoholic beverage types to see if one's choice—wine, beer or spirits—offers any advantage. Simply stated, what they found is that wine drinkers have better mortality than beer and hard liquor drinkers. Why? Because of something in the wine? Perhaps. But, there's also evidence to suggest that the advantages of wine may be less in the wine itself than in the health habits of those who choose the wine!

A recent University of California study of a large cohort of women with noninvasive breast cancer demonstrates this concept from a very different perspective but no less emphatically. (See references.)



**It's now an established fact that the mortality curve associated with alcoholic beverage consumption is u-shaped.**

These were women who had had what is called ductal carcinoma *in situ*. This form of breast malignancy, while not potentially fatal by itself, is felt to predispose a patient to invasive and thus life-threatening tumors.

What the authors found when they looked at mortality in women who had had such carcinomas in situ was that their risks of death by both cardiovascular disease and all-cause mortality were reduced by as much as 40 percent.

Does this mean that noninvasive breast cancer protects against coronary artery disease and fatal car crashes? Not likely! What it does mean is that women who opt to have periodic screening mammograms (most carcinomas in situ are discovered on a mammogram) also have other desirable health habits that make them better insurance risks. In other words, the decision to embrace periodic screening mammography may be a marker for a healthier lifestyle.

A recent report in the Archives of Internal Medicine on a large population of physicians who took low-dose aspirin to ward off heart attacks showed the same thing. (See references.) Those who chose to take aspirin for this reason were more apt to exercise regularly, to have a drink or two each day, to take vitamin E supplements, and to be faithful to any prescription they may have been given for high blood pressure or elevated cholesterol. These are highly desirable characteristics in life insurance applicants; they make better risks.

Is the decision to take "an aspirin a day to keep an MI away" in fact a marker for the presence of such healthful characteristics? As in drinking wine or having screening mammograms, the answer appears to be YES.

The same may now be said for postmenopausal women who choose to take hormone replacement therapy (HRT). Not only does the therapy itself appear to have significant risk-reducing impact, but the decision to take it also points to a high probability that the HRT user is a health-conscious individual. This has been revealed in several large studies, including one published in the *British Medical Journal*. (See references.) As a group, HRT users are better insurance risks than HRT disdainers.

If the foregoing are valid examples of how health-habit choices reflect risk, then why don't we start asking applicants about their patterns of (nonabusive) alcohol intake and their optional preventive medicine interventions, such as using aspirin, HRT, vitamin supplements, herbs, and perhaps other remedies as well?

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In fact, we have the wherewithal to take this approach even further.

A recent study in the *Journal of the American Medical Association* showed that when women were divided into quartiles based on their dietary patterns, those in the lowest (least favorable) group had significantly greater heart attack, stroke, and cancer mortality than those who embraced healthier diets. The medical researchers ascertained the relative merits of their subjects' diets by using a Recommended Food Frequency Score which, in turn, was derived from a food frequency questionnaire.

Could a modified version of such a questionnaire serve us in risk management? In the setting of nontraditional insurance (that is, with risk information gathered directly from the proposed insured), this should easily be accomplished.

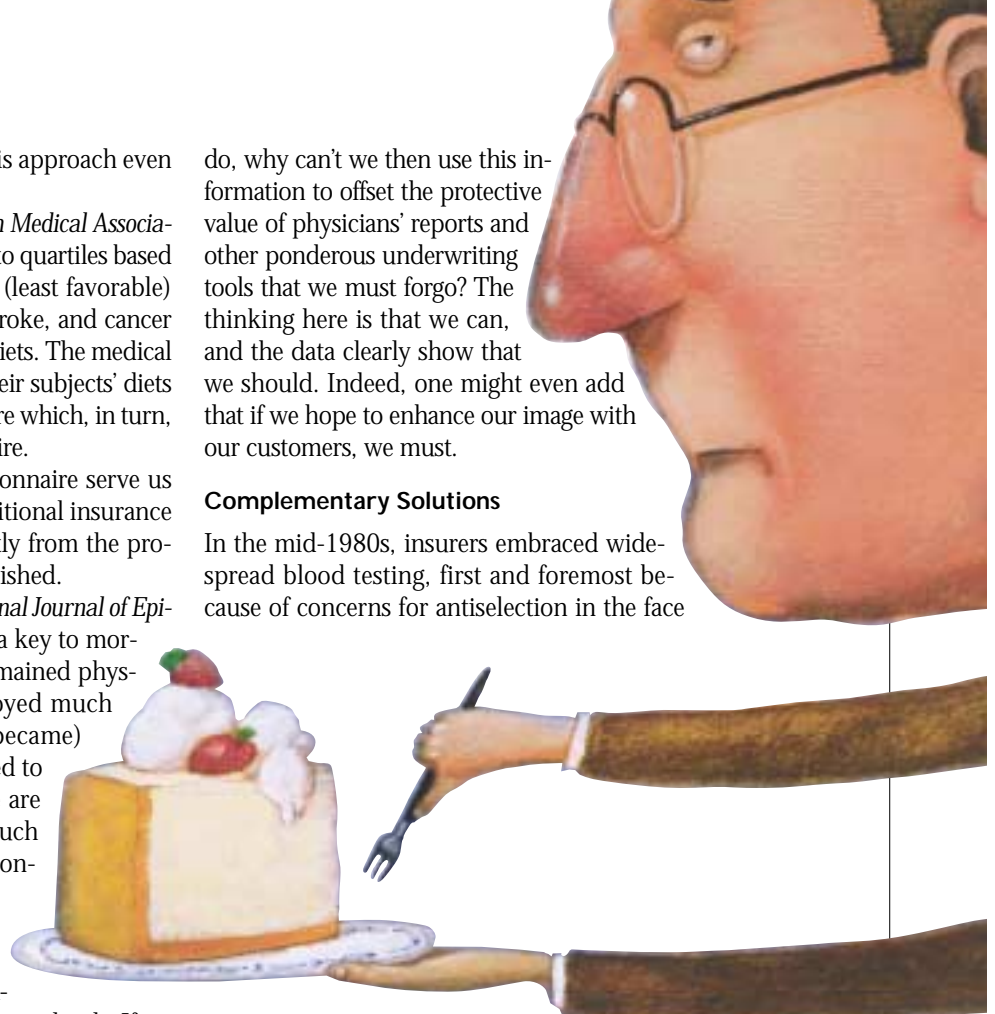
A Swedish study, published in the *International Journal of Epidemiology*, has shown that physical activity is a key to mortality. (See references.) Study subjects who remained physically active over a decade of follow-up enjoyed much lower mortality than those who were (or became) sedentary. The levels of physical activity judged to be "active" were not those of a triathlete! We are talking about leisure time physical activities such as bowling, gardening, and hiking actually conferring a mortality advantage.

The basic premise being advanced here is that we can embellish the PHI with strategically selected questions that get at valid risk markers, such as dietary proclivities and physical activity levels. If we

do, why can't we then use this information to offset the protective value of physicians' reports and other ponderous underwriting tools that we must forgo? The thinking here is that we can, and the data clearly show that we should. Indeed, one might even add that if we hope to enhance our image with our customers, we must.

### Complementary Solutions

In the mid-1980s, insurers embraced widespread blood testing, first and foremost because of concerns for antiselection in the face



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of the AIDS pandemic. Once they became comfortable with this new blood testing, insurers found real value in many of the blood profile components, most notably liver enzymes, diabetic markers, and lipid (cholesterol, etc.) tests. The veracity of this statement has been testified to by a bevy of published and proprietary protective value studies.

Now, in the 21st century, we turn our attention to what some call alternative fluids. By this, we mean oral fluid (saliva) and urine. Both are readily amenable to rapid collection and processing, thus qualifying them as a good fit with a rapid turn-around-time underwriting model.

Epitope Corporation, in suburban Portland, Ore., has developed an oral fluid test profile that's a near-perfect fit with this new risk management focus. It includes cotinine (a byproduct of nicotine, used to detect tobacco users with short memories), cocaine, HIV-1, and hepatitis B and C tests. Ambitious plans call for the potential addition of key tests for heart disease (c-reactive protein) and diabetes (glycated albumin) risks in the months ahead.

Calypte Biomedical, in Oakland, offers a user-friendly battery of urine tests. Like oral fluid, this includes cotinine, HIV-1, and drug testing. The key to the urine profile, however, is a test known as microalbumin. Originally conceived as a marker for early kidney damage in diabetics, this test is showing great promise as a broad circulatory disease risk marker of the same magnitude as cholesterol or high blood pressure.

These oral fluid and urine profiles allow underwriters to ward off antiselection, while gathering highly risk-relevant protective information and having to cope with the delays (and oc-

casional client angst) associated with blood collection. It's no wonder that some adventurous insurers will now offer seven figures of life insurance protection at younger ages using an alternative-fluid profile in lieu of blood tests.

The third component that fits nicely into this unconventional underwriting paradigm is the motor vehicle report (MVR). Accidents kill five times as many American males between the ages of 20 and 39 as does heart disease. The number one medium for fatal accidents is car crashes. Subjects with adverse driving records (and there's much more to an adverse driving record than just drunk driving) are usually risk takers, and risk takers are more likely to become death claims.

MVRs are fast and inexpensive. Coupled with an enhanced PHI, plus an oral fluid or urine profile, they provide the third key element of this new, fast, inexpensive risk management model.

### No More Nitpicking

We have the means to change the underwriting process to accommodate the priorities of nontraditional products. In fact, traditional insurers would also be well served to reflect upon the aforementioned potential of the PHI, alternative fluids, and MVRs.

By maximizing our use of these tools, we send a powerful message to customers: Underwriting is no longer about routinely nitpicking your medical history; it's about translating healthful living choices into access to affordable life insurance.

Instead of antagonizing customers, we create a covenant with them. ●

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