HANK GEORGE

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Rx = Dx

Part One

At the October 2001 conference of the Institute of Home Office Underwriters (IHOU) in Los Angeles, this underwriter presented a lecture titled, simple, "Rx = Dx."

Fortunately, its subtitle—"Pharmaceutical Information and Twenty-First Century Underwriting"—was a tad more illuminating, and the result (thankfully) was a large audience.

The narrative translation of the curious equation might best be stated as "tell me what he's taking and I'll tell you what he's got."

In other words, if, as a risk appraiser, I know a proposed insured is taking drug A versus drug B, I should be able to make certain inferences in many (most?) cases. *Which, in turn, could allow me to approve the application now, rather than leave it in purgatory orbit around my cubicle while some (uninspired?) attending physician struggles to find the time to decide what to tell me about his patient!*

Do I have your attention? Perhaps an example will help to clarify. Let's say you have two thirty-something female prospects. Successful young entrepreneurs… poised on the brink of more affluence than any home office underwriter can imagine! Both women report they experienced "emotional distress" of an ill-defined nature 18 months ago.

That hypertrophied portion of my cerebral cortex (which propelled me from undifferentiated liberal arts graduate to "natural born" underwriter) has been aroused… and I am in hot pursuit of an APS from each attending physician.

Let's further stipulate that: (1) both MDs are sluggishly unresponsive and (2) you just happen to need one of these cases to qualify for a cruise up the coast of British Columbia.

The first woman was prescribed five milligrams of buspirone (Buspar), three times a day.

The second was given a prescription for 75 milligrams of venlafaxine (Effexor XR), two times a day.

Can I, as an underwriter, knowing this added bit of prescription information, make any legitimate inferences? *You bet.*

I can infer that, in all probability, the first applicant had an encounter with mild-to-moderate, uncomplicated anxiety to an extent unlikely to compromise her insurability (at least where life insurance is concerned).

I will also hazard to say that the second woman—whose history requires further clarification given the chosen medication—also has a very strong possibility of being insurable "as applied for." However, the difference between the first prescription and the second mandates that I go further with the second case before coming to that conclusion.

Had the second proposed insured been given lithium carbonate or olanzapine, my preliminary assessment would have had to be far less optimistic, and the need for the APS correspondingly more urgent.

As you can see, the nature of the prescription strongly influences both my preliminary judgment and my course of action.

On the first case, I am quite willing to

entertain further explanation from the client potentially in lieu of that APS. Indeed, if the facts surrounding this history of "emotional distress" are adequately addressed in the Part II, in the personal history interview, or even in your cover letter (you did write one, yes?), no further information may be needed at all.

Case approved. And that is why this message is so important.

At this time in the evolution of our industry, insurers find themselves struggling with many considerations bearing on how they assess risk and, thus, ascertain insurability.

Some underwriting tools, which dominated in the twentieth century, have outlived their usefulness and are being largely or wholly abandoned. They are being replaced by other options deemed "faster, cheaper, and better" (the title, I hasten to add, of a forthcoming Society of Actuaries seminar on this very subject!).

The most enigmatic of those requirements in a current state of flux is the APS. The APS has been, paradoxically, both the anchor and the albatross of risk appraisal.

When it is obtained promptly and its contents are adequate, it is a priceless resource in many cases. However, "prompt, adequate" caveats are increasingly less likely to be realized for a variety of reasons we don't have time to delve into in this essay. Bottom line, the net result is that most insurers are actively looking for ways to lessen their reliance on physicians' reports. That is, of course, without significantly compromising their mortality results.

A recent informal (and unpublished) survey, undertaken by this under-writer with members of several life underwriting study groups, is very revealing in this regard. Even now, the "age and amount" APS remains collectively more prevalent in day-to-day industry-wide underwriting than the APS ordered "for cause," (that is, based on the medical history as revealed on the Part II, etc.).

This will change with the maturation of the so-called "teleunderwriting" process. And the change will extend to involve decreased dependence on "for cause" physicians' reports as well.

Insurers will…indeed, must…en-deavor to separate "the wheat" from "the chaff," as it were, in this regard. Not all psychiatric histories mandate an "automatic" APS. Ditto for all bouts of "colitis"…and so on.

This process will be catalyzed by an enhanced capacity to make risk-related judgments based on expanded histories taken from the client via telephone interviews and embellished with new underwriting skills and resources.

One of those "skills" will be greater awareness of—and reliance upon—prescription information. This includes prescribed drugs and those taken over the counter without a prescription, as well as the use of medicinal herbs and other forms of alternative and complementary intervention.

In my next essay, I will look more closely at this new approach and endeavor to explain in some depth how this will be possible.

Stay tuned. ○