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Teleunderwriting: Part 2

A Tale Of Twenty-First Century Reality

Author's Note: *In August, I changed course to cover critical illness insurance. It generated more feedback to me than anything I have ever written! Awareness of and interest in this fascinating new product is growing by leaps and bounds. In June, I asked and answered key questions about what this phenomenon we call teleunderwriting is all about. If you get a chance, you might want to re-read that essay.*

Teleunderwriting embraces multitudes. It is, at the same time, both a technical process that reconfigures day-to-day home office underwriting and a dynamic process that affects every aspect of how we select risks.

Let's explore the technical aspect first. Teleunderwriting makes extensive use of the telephone as an information gathering resource. One day, the Internet should play an equivalent role...but, for now, the telephone is our focus.

The key information gathering resource is the personal history interview (PHI). This entity may go by a variety of other names as well. However, the concept is basically the same.

The proposed insured agrees to be interviewed and, ideally, the producer facilitates completion of this vital interview by gaining his client's agreement as to the date and time it will take place.

The interview is conducted by one of three people, depending on how the insurer organizes its teleunderwriting operations: an underwriter, an in-house caller who is not an underwriter; or an outsourced

caller who is not (in most, but not all cases) trained as an underwriter.

[As an aside, this underwriter has yet to appreciate the merit in asking home office underwriters to undertake what is clearly an information-gathering function. The Mayo Clinic quickly discovered the downside of asking physicians to question patients about use of alternative/complementary remedies, like St. John's wort and ginkgo biloba. Their doctors got about half as many truthful answers as a "pleasant female voice" conducting a non-threatening, non-judgmental telephone interview! Enough said.]

The decision to do interviews in-house (versus outsourcing them to one of a growing number of fee-for-service providers) is one of the most important decisions any company will make in its embrace of teleunderwriting. Both approaches have pros and cons.

The actual interview may last anywhere from under 10 minutes to as long as 15 or even 20, depending on two factors: how many questions are asked and, of course, the length of the answers.

If the interview is limited to a reprise of the risk-related questions on the application, it will be shorter

than one also making use of drill-down questioning of all *yes* answers.

In this context, shorter is definitely not better! Drilldown questioning is the cornerstone of the interview. Why? Because drilldown questioning elicits protective information that may allow the underwriter to make a decision *without ordering more requirements!*

Especially the attending physician's statement (APS), which is the slowest and the most expensive underwriting tool we use. I just got a note from the chief underwriting officer of one large company undertaking a very comprehensive commitment to teleunderwriting. He tells me that in the first few months since implementation of their efforts, APS ordering is already down 50 percent.

Fifty percent! This means half of the cases that would have loitered in underwriters' pending files for weeks (average APS acquisition time is still 15 to 20 days) came to final action in a much shorter interval. In many cases, the same day the underwriter cast his eyes on the illuminating PHI interview with drilldowns of all *yes* answers.

This underwriter, in his new life, now specializes in helping companies fashion their drilldown questions so as to optimize disclosure of risk-salient information with as few questions as possible. The better the questions, the better the protective information. Higher quality information means more decisions can be made without additional requirements.

A recent conversation with another chief underwriter, whose company has been doing telephone interviews longer than most, disclosed these revelations. Turnaround time has never been faster; producers have never been more pleased. The wealth of protective information acquired via telephone interviews with drilldowns now exceeds

the payoff from age/amount physicians' reports as well as those ordered "for cause" on many impairments.

Sure, they still get APSs for invasive cancer, coronary disease, etc. No drilldown can replace the path...or cath...report. But you'd be surprised how many times the APS becomes clearly redundant in the face of an excellent PHI.

The success of the personal history interview is contingent on the knowledge base of the home office underwriter. Take for example the matter of prescriptions. If I know which drug the physician prescribed, and in what dosage, I may be able to make a very significant inference as to the underwriting importance of colitis, asthma, seizures, and even chest pain, as reported in the medical history.

Outstanding PHIs always go to considerable lengths to pinpoint all medicines taken by the applicant...by prescription *and* over the counter (supplements, herbs, etc.).

This concept extends beyond prescriptions. In teleunderwriting, underwriters use this same risk triage technique when it comes to surgical procedures, diagnostic tests, symptoms experienced, and other variables that are meticulously elicited during the interview.

This is *real* underwriting. No wonder most underwriters give a thumbs up to *teleunderwriting* once they have been exposed to it in action.

Looking at the broader impact of *teleunderwriting*, we see that the goal is making as many decisions as possible, as quickly as possible, at the lowest (true) cost to the insurer—and achieving all of this without compromising mortality expectations (or causing their reinsurers to turn prematurely gray).

Turnaround time will be a bigger and bigger issue in the future. Non-

traditional distributors, like banks and Internet providers, will make it so.

Controlling costs is already a major issue. It has to be. To achieve acceptable mortality results while controlling business acquisition costs, the insurer is obliged to take a fresh look at how to select risks. What is the *real* cost of those chest x-rays (most of which end up being relegated to the trash heap of history) and those electrocardiograms...not to forget any APSs you don't really need. Then there are those lab tests, medical exams, inspection reports, and so on.

The cost of a requirement is much more than the fee paid to acquire it.

Important questions need to be asked and answered objectively.

- How long does it take to get the requirement? Time is money.
- How much does it really cost the company to make use of that requirement?
- How much *genuine* protective value does the requirement ante up, to justify its continued employment as a screening and/or reflex tool?

A recent study published in a leading cardiology journal showed that 55 percent of NFL football players have at least one significant ECG abnormality.

How often would such abnormalities translate into appropriate adverse underwriting action? How many of these highly conditioned, medically scrutinized individuals would you expect to (justifiably) debit significantly for ECG changes? I don't know the answer, but I can't believe it is anywhere near 55 percent.

At age 25 or 30, how much does a cholesterol reading really tell us? As compared to smoking a pack a day or having a lengthy motor vehicle record?

Who says, "You can't do preferred without cholesterol?" at ages 18 to 39 and over 65? Not anyone who has

thought about the question for more than five minutes.

Do MD examiners *ever* find *anything* of value? Do they ever take a close look—you know, as they surely would if the proposed insured were their own patient—not for a one-time encounter for an insurance company?

These are the kinds of hard questions insurers need to roll up their sleeves and ask.

“We’ve always done it that way,” won’t cut it. It shouldn’t.

Underwriting resources that inte-

grate into a faster, cheaper, better core risk assessment protocol will carry the day.

These resources include—first and foremost—the PHI with drilldown questioning, plus MIB checks, MVRs, physical measurements (especially at ages over 40), producer-facilitated oral fluid and urine profiles (in lieu of blood profiles at younger ages)...and, potentially, Rx and other database profiles which are already being offered.

There is much more one could say about *teleunderwriting*. But now, at least

you have a better feel for what it could (no...make that *should*) encompass.

One thing is certain. The future will be challenging, as it compels us to meld underwriting savvy with the realities of the twenty-first century insurance marketplace. *Good!* o

So, let me remind everyone about the World Critical Illness Conference. Vancouver, BC, Canada, January 14-15, 2003. Visit www.criticalinsurance.ca for a preview.

Delegates are coming from across the continent and around the world to hear the best array of speakers ever assembled lecture on our next big product: critical illness. You can learn all you must know about CI in just two days! See you there!