

Underwriting Reinvention

Is it time to step up to the plate...

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Underwriting Reinvention



**....and “juice up”
your underwriting process?**

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Quicker, Cheaper, Better...

We're Stuck in the 20th Century

- **APS's**
 - **Expensive. \$50+ including physician and vendor fees**
 - **Time Consuming. Average 2 weeks+ from time of order to receipt**
 - **Results in high drop rates**
 - **Producers hate them**
- **Exams**
 - **Quality variability**
 - **Often lack critical details**

But

- **They are generally cost effective**
- **Reinsurers love them**
- **Are they all necessary ?**

No !!

APS's

- **Why are they ordered ?**
- **Which ones are protective ?**
- **What is the real value of impairment specific APS's ?**

Do the cost benefit work !

In a typical (but hypothetical) APS C/B study, you might find the following

<u>Reason for APS</u>	<u>% of Total APS's</u>	<u>Annualized Present Value of Future Mortality Savings</u>
Cancer / Heart Disease	15%	\$3,400,000
Older Age (60+)	9%	\$6,300,000
Large Amount (\$1M+)	4%	\$5,500,000
Blood Pressure	21%	\$9,500,000
Asthma	4%	\$ 800,000
Diabetes	2%	\$1,000,000
G.I.	3%	\$ 200,000
Age / Amount	24%	\$2,700,000
Liver / LFT's	3%	\$ 500,000
ETOH / Drugs	2%	\$ 400,000
Depression / Psych	6%	\$ 700,000
Build	2%	\$ 250,000
MIB / Misc	5%	\$2,700,000
<u>Total</u>	100%	\$33,950,000

What Jumps off the Page?

- **Cancer / Heart / Older Age / Large Amount APS's represent 28% of APS's ordered, but 45% of protective value.**
- **Conversely, the other 72% of your APS's yield 55% of total APS protective value.**
- **What if you eliminated the least protective APS's and replaced them with equally or even more protective requirements?**

The Cost / Benefit Study

- **The requirements must be the sole source of the protective information.**
- **The benefit must exceed the cost.**
- **Included in the cost is:**
 - **The dollar cost of the requirement**
 - **Processing costs. Mail match, underwriter review time etc.**
 - **Lost business**

What if you :

- **Eliminate routine age / amount APS's ?**
- **Eliminate blood pressure APS's at certain ages ?**
- **Eliminate asthma, GI, depression, build and MIB / misc. APS's ?**

Result :

- **You "lose" \$16,850,000 in protective value**
- **You eliminate 62% of your APS's (20,460 APS's assuming 100,000 annual apps and a 33% APS order ratio)**
- **You save a minimum of \$1,330,000 in APS processing costs (\$65 includes \$10 "incidental" costs)**
- **You save unknown costs due to faster issue time and fewer dropped apps.**
- **But you are still \$15,500,000 in the hole !**

The Answer ?

Underwriting Reinvention !

A pen nib is positioned on the left side of the text, and a syringe is positioned on the right side. The text 'Underwriting Reinvention !' is written in a bold, black, sans-serif font and is slanted upwards from left to right.

Underwriting Reinvention

- **Tele-app**
- **Lower blood testing limits**
- **A1c screening**
- **PSA screening**
- **BNP screening**
- **HCV screening**
- **Rx Check**
- **Drugs of abuse screening**

Every one of these options is faster and cheaper than an APS

Tele-App

- **Easily replaces many routine APS's**
- **Far less expensive**
- **Takes less than ¼ the time to obtain**
- **Recorded interview eliminates most of the “he said / she said” claim disputes**

Lower Blood Testing Limits

- **Tobacco misrep is a problem with untested business**
- **Tobacco use rates are highest at the lower face amounts**
- **Assume a 100,000 app plan**
 - **80,000 declared non-tobacco users**
 - **20,000 admitted tobacco users**
 - **With 10% tobacco misrep rate your missing 8000 tobacco users with average mortality of 4 tables**

Lower Blood Testing Limits

- **Ask your actuaries how 8% of your business mis-priced by 4 tables affects your bottom line**
- **Are you willing to ask your honest customers to subsidize the “leakers”?**
- **Now add in the additional protective value from HIV and cocaine positives and other blood test components**
- **Where is your positive nicotine cutoff? 0.50 ? Industry moving to 0.25 or 0.30**

A1c Screening

- **Routine blood glucose is unreliable**
- **Specimen handling artificially lowers glucose readings**
- **A1C is highly stable with proven links to glucose intolerance as well as coronary artery disease**
- **Would you issue best preferred with an A1C of 6.2 ?**
- **Would you issue standard with an A1c of 6.8 ?**

A1c Screening continued

- **A number of companies have found 20—30% of applicants with normal glucose readings have abnormal (>6.0) A1C.**
- **Not all A1c's above 6.0 will be protective but companies that have done the C/B work find that it is a significant percentage.**

BNP Screening

- **NT-ProBNP – a neurohormone produced by “stress” in the heart muscle**
- **Provides information not already provided by the most common markers of cardiovascular disease such as hypertension, cholesterol, diabetes and tobacco use.**

BNP Screening

- **According to the Journal of the American Medical Association “elevated levels of NT-ProBNP predict cardiovascular morbidity and mortality, independent of other prognostic markers, and identify at risk individuals even in the absence of systolic or diastolic dysfunction by echocardiography”**

(JAMA 1/10/07 vol 297 No 2)

BNP Screening

- **In other words, NT-ProBNP can identify at risk individuals before the risk is detected by other means.**
- **Widespread acceptance in clinical medicine**
- **Can easily be added to your blood profile**
- **Has very high specificity (low false positive rate)**
- **Extremely high protective value and a cost / benefit “no brainer”**
- **Replace treadmill and / or resting EKG’s**

And On, and On, and On

- **We haven't touched on:**
 - Rx Check
 - PSA screening
 - Drugs of abuse screening
 - HCV screening
- **Our \$15,500,000 shortfall ?**
- **Do the cost / benefit work !**
- **Or hire someone to do it for you**



**You may just hit one out
of the park !**

