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Session 49PD
Session Title: The Actuary and Underwriting

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Moderator: Mark E. Billingsley

Panelists: Dawn E. Helwig
Stephen K. Holland†
Bernard Rabinowitz
Stephen Rowley‡
Gregg R. Sadler

Summary: In this session panelists present an overview of underwriting processes for a variety of product lines. They also discuss related topics such as identifying keys to underwriting decisions, the cost of underwriting and protective value, and ensuring consistency with pricing assumptions. Attendees gain a good understanding of how actuaries and underwriters can work together to achieve optimal results.

MR. MARK BILLINGSLEY: I'm reminded of an industry cartoon a few years ago in which an individual is being told why he was not accepted for insurance. The underwriter explains, "Well, frankly, sir, we prefer to issue policies to those who don't need it." You might think that's somewhat funny, but there's an element of truth to that. If everybody who applies for insurance needs the insurance immediately, we're no longer talking about insurance. We're just talking about ways to pay for things that are known to be occurring, so it's no longer risk sharing. It's just a social financing method.

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Underwriting is critically important, as we all know. I have a great panel to talk about this today that will give a variety of perspectives. We have a medical actuary, Bernie Rabinowitz, with Reden & Anders. We have a senior product actuary, Dawn Helwig, from Milliman USA. We have an underwriter and a reinsurer perspective given by Steve Rowley of General Re. We also have a medical director and TPA perspective from Dr. Stephen Holland from the Long Term Care Group. We have a vendor of underwriting tools and underwriting requirements, Gregg Sadler, the president of LabOne. I will give a few comments from a company actuary's perspective.

There are a variety of elements to the relationship between actuaries and underwriters and the underwriting process. We're going to talk about the communication, which is obviously the first step to gaining a relationship between the two critical elements of risk selection, and about the coordination of activities between the two areas. We'll talk about underwriting requirements, as far as some of the critical elements in deciding what requirements you have in the underwriting process. We'll also talk about the relationship between the cost of doing underwriting and the protective value of that underwriting, and then about some other constraints on the underwriting process.

Let's start with communication. The first step, obviously, in any product is the design process, identifying what a specific product is going to pay for. That's where the discussion needs to start on any particular product. Dawn, could you, from a consultant's perspective, give us some thoughts about how the design process starts the underwriting considerations?

MS. DAWN HELWIG: Maybe some of this is quite obvious, but one of the initial things as part of the design process is trying to figure out who the target market is for that particular product that you're designing. I specialize in senior products. I'm primarily Medicare supplement and long-term care. As an example, on the Medicare supplement side, you can have an agency force that's primarily going to solicit 65-year-olds as they turn 65. In that case the product has to be guaranteed issue at that point and underwriting is somewhat moot. However, if you have a sales force that is going to be actively searching and doing rewrites of existing policyholders, underwriting could come into play. There you need to decide what level of underwriting you're going to do. You need to understand where your marketers are going to be focusing, what their market is going to be and what level of underwriting you can or want to be doing there.

As another example, on the long-term-care side, there are companies out there that have a number of different risk classifications and have made a niche for themselves of having some substandard risks or a little less optimal risk that they will take for which they charge a higher premium. That full design process, understanding who you're going to be marketing to and what level of underwriting you can do in that market, is very important. On the long-term-care side, part of

the NAIC model regulation now says that the actuary has to certify that he or she has looked at the underwriting and the claims process, that he or she is aware of what's going to be done and that's been built into the pricing. The actuary needs to get involved with the underwriter very early on.

MR. BILLINGSLEY: Steve Rowley, could you elaborate on how it is a benefit to get the reinsurer and the underwriter involved early in the product development process?

MR. STEPHEN ROWLEY: We handle those in two different directions. Bring the underwriter in — that may be your own if you're not reinsuring, but certainly if you do plan to reinsure — make sure you're in line with the reinsurer before you roll out the product. One reason for getting the underwriter in line is that sometimes the underwriter understands in a different way the risk of your components of a product. I'll give an example. In long-term care right now there's a big push for worldwide coverage. There's a difference whether that is issued as a rider versus included in the policy. Obviously, with a rider, there will be more anti-selection. The advantage of a rider, though, is that if you determine you made a mistake by offering it, you can pull it without refiling. Those are the types of discussions that you would think the actuary should be thinking about in advance, but sometimes you have to bend down and ask, "What does this mean?"

As far as the reinsurer, one struggle that we have as a reinsurer, and some of our clients have, occurs when they've got their product fully built, it's up and running, and it's already been filed. Then they come to us for reinsurance. It puts the reinsurer in a position, if a reinsurer is what you need on your product, of a thumbs-up or thumbs-down situation, which isn't good for the reinsurer or you. You should pull the reinsurer in early in the design process, and find out what their hot buttons are; the certain things that the reinsurer wants to stay away from. In some lines of business, like long-term care, the actuary should be signing off that he or she is aware of underwriting, but there's a little bit of a disconnect if you're using a reinsurer's manual, and you've already filed your product and the actuary has certified the product without even knowing what reinsurer you're going to go with or what reinsurance underwriting manual.

MR. BILLINGSLEY: The next step in the product-development process is pricing. Obviously it goes along with design, but pricing is the critical element where you really need to know what level of underwriting you're going to be able to do. Bernie, do you have some thoughts about medical underwriting?

MR. BERNARD RABINOWITZ: In individual medical insurance, there's a big difference between the attitude of the people who buy the product versus the people buying other lines of business. Normally, people buy other lines of business for asset protection, and I guess in individual medical insurance, you're protecting assets. In other words, you don't want to spend a lot of money if something happens to you. But people buy with the idea of immediate consumption, whereas

life insurance is when you die, long-term care is when you are old and disability income is thinking that you're not going to get sick tomorrow. But in individual medical, people are doing cost-benefit analysis. What's happening is that people with mild discomforts, people who are not really sick, use the system a lot, so the underwriting process has to deal with that.

I want to mention one or two things on product design. The most important thing in product design is where you want to position yourself in the market. If you have rich benefits, you're going to attract users. If you have skinnier benefits, you're going to attract those people who are more concerned about catastrophes. The other thing that you have to do in design is watch for holes. For instance, a lot of states don't allow you to put a limit on chiropractic benefits. That's one of the most abused types of medical expense. I see a tendency now by companies to pay a limited benefit for spinal manipulation, no matter who does it. The other thing is the mental/nervous benefit — big item, very subjective. You have to figure out how to box it in and limit it.

Talking about pricing: The marketplace determines prices. This is what's happening in individual major medical. It's an expensive product; it's a huge outlay. You've heard the numbers. The average premium under individual medical is about $3,000 a year, and that's with fairly high deductibles. If you want lower deductibles, they cost very much more than that. So pricing is very competitive. Agents have spreadsheeted companies all over the place. The question becomes, are you going to have loose underwriting, or how do you effect your underwriting into pricing?

It's less of an issue in the medical business because what's happening out there is that if your underwriting rules are weaker than somebody else's, in other words, if you take borderline diabetics (people who don't have diabetes but they have high blood-sugar levels), then pretty soon the brokerage community is going to say that your company is the diabetic specialist, and that's all you're going to see. In pricing, the main issue is building in the costs of underwriting. We're going to get into that later.

MR. BILLINGSLEY: The next step is product implementation. Obviously, once the product has been designed and priced, it's then a matter of trying to implement that and making sure that the considerations that were developed in the product development process are then implemented in the underwriting field. Dawn, do you have some ideas on how that step is critical and how best to do that?

MS. HELWIG: It's key, in tying into the communication aspect of this, that during that product implementation procedure there be heavy communication between the underwriting area and the actuarial area in terms of what they're seeing with the applications coming in the door. You want to know how that's comparing, what they're doing with it and what they're doing with some of the conditions to make sure that it's in line with what the actuary priced.

Taking that a step further, a number of companies would, optimally, have regular team meetings between actuarial, underwriting and claims. The claims people would bring early duration claims back to this team to look at and see if there was something missed in the underwriting process. Again taking long-term care as an example, you're trying to underwrite out people who have cognitive impairments, Parkinson's or some of those sorts of conditions. If your first few claims coming in the door are for something that you thought you were underwriting out, then you have to do a very close check on your underwriting process.

As an example, a person I worked with was involved with one of the very first companies that did long-term care. The company had this sort of process in place. The first claims in the door were all for Parkinson's. They went back and looked and found that, lo and behold, their application didn't ask if the person had Parkinson's. There are some big holes that you can discover quickly, and need to discover quickly, through that back-and-forth process.

DR. STEPHEN HOLLAND: To reiterate what Dawn said, at least in our company and in a lot of other companies, the application and the underwriting protocol are all signed off by underwriting. Because obviously, many of the things that you're going to do when you go investigating for cause at different age groups will be based on answers that are noted on the application or, perhaps, gained in a phone interview. I also think the important things in implementation, at least in the individual arena and also in the group arena, at least in long-term care, are the issue of a good agent's guide, good training of agents and having phones available for triage so agents can call in and ask questions about this person's potential. Of course, most agents think that if we say to send in the application that that means they're going to get approved. Agents sort of miss that last sentence when we say we're going to have to look at the entire case before we can make a decision. Some agents are surprised when we find out that the applicant is far sicker than they believed.

As far as the issue of training, many insurers today in long-term-care insurance have specialists who are specially trained individuals who do a lot of training in the field. Training agents can mean the difference between a decline rate at 65 percent versus 20 percent, which could be very costly to a carrier. Agents don't want to spend time on cases where they have a high probability of not placing a policy. The more that you can do in underwriting, whether that be disability, life or Medicare supplement, to train your agents and to give them the tools so that they can pre-qualify an individual, the easier the underwriting job and hopefully the better the risk will be.

MR. RABINOWITZ: The individual medical slant on this is that what you're really doing is underwriting for what I call "mild" conditions. The severe conditions are a decline because, otherwise, you're just going to be buying claims. When you're dealing with mild conditions, then what happens is that there's quite a bit of subjectivity in it. It's hard to produce guidelines for the field because they want a reasonable assurance that if they write the case, somehow it's going to get placed.

Quite often they're writing family coverage where there are four members. If you're writing four people, one of them is going to have something wrong with him. It may not be severe, but there will be an underwriting decision on somebody. So they need to know, particularly when they're taking an application, that there are about 93 questions on it. When you look at the application, there are only about 12 questions. But if you read each question, there are subparts to each. In a typical application, when you add up all the little pieces, they put in 90 questions. All have to be answered, and nobody takes an application without the first premium, which is an average of about $250. Training of agents is absolutely critical in what a company will accept and won't accept to avoid disappointment.

It's also extremely important to work closely with the claims department because in the first year you get a lot of claims. It's important to understand whether somebody has found a way of beating the system or this is just the way it is, or maybe we need better underwriting tools.

MR. ROWLEY: Dr. Holland mentioned that the best thing to do is to have a good field guide for the producer. That is probably, in my opinion, the most difficult thing for an underwriter to build. You can't put the entire manual out there, obviously, because then they're going to select against you in the worst way possible if they know everything you do. I've seen field guides that look like a manual. They're running 3-in. thick. No one ever looks at them. They have every answer in there, but no agent is going to carry it. The little trifolds that have the most common impairments with good ball park are great. An agent will occasionally look at it, but you can't get into all the degrees of offers that you might get or the detail. So what happens with that? It's a double-edged sword. They use it, but then what you put there is what you think the most likely decision will be for, say, osteoporosis. Then when the underwriter gets the detail and, of course, the manual back home breaks osteoporosis into 15 different possible decisions, it's not what the field guide said is insurable. So if anyone here that has ever done the field guide right, where it's actually helpful and utilized, I'd love to see it. It's a huge struggle for underwriters to put enough in there, but not too much, have it represent what we do and have someone use it. I don't know if anyone has had better luck with field guides than I have.

MR. BILLINGSLEY: If it's accurate, every line says "individual consideration," and that's essentially no help at all.

The next step in the development implementation of a product is the flow of the production. As the business comes in and the underwriters are starting to look at the business, that's another critical stage in which the actuaries probably need to be talking to the underwriters and making sure that they're seeing what they expected to see. I think we've touched on that a little bit. Does anybody have any other comments?

MR. ROWLEY: If you're doing a major nationwide launch of a new product, I've found that companies who have the resources, the staff and the money run a good model office first. There's nothing worse than if you fall on your face when that thing first comes out because of a technical glitch in the issue process. It's amazing. The largest, most successful companies can do it. Run model office for a few weeks first of running fake applications through the system and making sure everything works is the best scenario. Short of that is bringing up the first two smaller states well in advance of the nationwide roll-out. No matter how much you plan, when it's a new product and it's going to be on the system in a different way, something is going to fall through the cracks and embarrass you. It's better to be embarrassed in a smaller state than in a bigger state where you're going to have a lot of agents who are going to be pretty upset. Do a slow roll-out to work out the bugs. I haven't seen anything come out yet that didn't have a few bugs in it.

MR. RABINOWITZ: In experience analysis, people think in terms of looking at loss ratios. But what's absolutely critical, in my opinion, is to set up all the experience analytics needs up front because when the time comes to look at the experience, you're usually project number 564 on the IT's list, with agents' commissions being No. 1.

People tend to think of experience analysis in terms of loss ratios, but I think what's very important is what I call "risk profiles." You've got to understand what's coming in and how what's coming in is changing over time. What I mean by risk profiles would be a concentration of risk at particular ages. That could tell you that there may be a problem with your manual. There could be a concentration of risk in certain ZIP codes. You may be underpriced in those ZIP codes. Remember, in the individual medical business, companies in the metropolitan areas are rating by five-digit ZIP code. You have to understand exactly where you're writing the business and the socioeconomic conditions of various parts of the major cities. You're looking for concentrations over there.

You're also going to be looking for concentrations in what I call "mild" impairments. How many asthmatics are you getting? How many overweight people are you getting? How much are you getting from a particular broker? If you're working through a general agency system, how dependent are you on individual brokers? How are these numbers changing over time? You can learn a lot, but that has to be set up up front so that as the business rolls in, you're collecting the numbers and looking at them.

DR. HOLLAND: I would echo that, especially in long-term-care insurance. We had the opportunity to build our system from the ground up before we became an administrator. Coming from an academic background, we wanted to collect everything. But understanding that each bit of information costs money, we did come to an agreement on a good set of data points, such as having diagnosis. Beyond diagnosis, have a measure of severity so if you know that somebody has diabetes, you know what medications the person is on and you know how long the person has had it. There are functional lifestyle measures, like smoking. Those are

important things that if you don't collect them in a machine-readable format, an analyzable format, at the beginning, then five or six years down the line you're not going to know what is producing claims. On the claims side, you must understand the diagnosis that's producing the claim. Was there a precipitating event? What is the level of disability? Those are very important so you can tie claimed events back to your underwriting. I can literally look at the experience of individuals with atrial fibrillation who are on Coumadin versus those who aren't. I can then look at the claim experience five or 10 years down the line and separate those who were hit by a car and broke their necks versus those who had strokes, which is one of the outcomes that we would expect from atrial fibrillation.

You've got to collect that type of data. Each of our product segments probably has unique data elements. That is a challenge because most actuaries aren't thinking in terms of diseases. To an underwriter, that's all what we think of. We don't think in terms of incidence rates. I'll go to my actuary and say, "The overall expected to actual risk pool is performing very well. We're at 50 percent at 10 years. But look, I have this group of diabetics who have claim rates that are 300 percent greater than everybody else. Is that too much? How about 250 percent? How about 100 percent? But the overall pool is doing great. It's 50 percent of expected."

You have to understand that there still exists this huge chasm between underwriting and actuaries because we think in terms of diseases. Where do I draw the line on somebody who has asthma? Is it one med? Two meds? Three meds? Is it a pulmonary function test? I would love to come to you and ask where I should draw that line. Instead, we are left with devising these lines in the sand, whether it is medical, life or disability. We don't have a way to tie disease-specific incidence rates back to age bands that actuaries think in. While we look cross-eyed when we see your morbidity table, I think, even though the NAIC says you have to sign off, you're looking cross-eyed when you look at our criteria.

MS. HELWIG: This whole experience analysis issue is one of my pet topics, too. I think all of you have probably heard the actuarial duck-hunting joke in which two actuaries are out duck hunting. One shoots and misses way to the left. The other shoots and misses way to the right. They start jumping up and down saying, "We got him! We got him!" I think that's what we have going on here. The actuaries look at that 50-percent loss ratio and say, "We got it. We're right on. That's where we wanted to be." The underwriter is over here looking and saying, "But how about this outlier? Should I have taken him or not?" The claims person is maybe saying likewise.

Ultimately, to be able to bridge that gap and to get the actuaries on base with being able to help the underwriters and the claims people in deciding whether these are risks they should or shouldn't be taking. For example, what do we expect for this diabetic 10 years later? We need the data, obviously. To have the data we need the systems. Historically speaking, insurance companies have been greatly lacking in both of those things.

Steve's company is fairly unique because, like he said, they did build the system from ground up in terms of being able to try to take account of when they take an application, what conditions that person has, exactly what is on the application and what you know about them, then putting it all in the system and tracking it. Hopefully, as we progress with more of that kind of data available, we'll be able to do more of those things.

MR. ROWLEY: There's another area in experience analysis where I think the industry started down the right road a few years ago and then backed off. The underwriters really have to rely on the actuary to bring either the group or multi-life market. Two-and-a-half years ago, we were all talking about concentration of risk, life, property and casualty (P&C) and disability. Terrorism became this huge concern. I know we had a number of people who were within a three-block radius of the financial center. Are you able to see, when something comes, what your concentration is for that risk?

Certainly, because of the nature of that catastrophe, everybody, shortly after 9/11, said that was a life insurance risk, not a disability insurance risk. The disability insurers fared fairly well after 9/11. We're a very reactionary industry. Then we had the train bombing in Spain where the death toll wasn't that high, but the disability toll was tremendous. So rather than always being reactionary, be able to think through all your product lines and know to a ZIP code what your concentration is in one area. One thing you have to look at when you've got 3,000 people in one building is the potential hit to you. There was a lot of talk at these meetings and other meetings shortly after 9/11, and that talk has generally disappeared. I haven't seen a lot of companies that have really built an aggregate system where they could say what their exposure is, especially companies that have both P&C and life and health products. I would encourage people to continue moving there. As underwriters, we'll often go to go to the actuaries and ask, "We're prepared to make a large group or multi-life offer. What's our exposure in this area?" The answer is usually, "I don't know."

MR. BILLINGSLEY: We're going to delve a little deeper into the coordination process. With respect to the pricing assumptions, Dawn, could you talk a little about the impact of the level of underwriting? How do you factor that into the pricing assumptions?

MS. HELWIG: The level of underwriting has two different impacts. The first is, obviously, on the selection factors and the morbidity that you're going to assume. That can be reflected in the durational selection patterns that you use in the pricing, how long that selection goes out and in the ultimate morbidity that you're using, too. If you have a group of policyholders that you're going to be guaranteed issuing, like Medicare supplement, you may have just an overall ultimate morbidity on those people. Maybe it’s 10 percent worse than if you're going to do some basic accept/reject type of underwriting, just because you let through the door a lot of

people in worse health. So it can affect not only the durational selection factors, but also the ultimate morbidity level.

The second thing that the level of underwriting affects in the pricing is your expense assumption. How much underwriting you do, what the cost of the underwriting is and then what the reject rate is — the expense assumption is what that underwriting cost translates to in terms of the underwriting cost per policy issued. Both of those things are going to be dramatically impacted by the level and the style of underwriting you choose.

MR. BILLINGSLEY: The intensity of underwriting obviously goes into some of the things that Dawn just touched on, but Bernie, how does the intensity of underwriting impact the coordination process?

MR. RABINOWITZ: The intensity of underwriting is related to the pricing, and that's why I'd like to talk about both of them. What seems to be happening just this last six to eight months is that clients have been asking, "If we increase the intensity of underwriting, how much can we lower the rates?" There's a lot of price pressure out there. I think the underwriting cycle is just beginning, and I think it's going to intensify as companies get more into the health savings accounts (HSAs) business. Who's in the individual medical lines of business over here? Is the latest buzzword in your company "HSAs"? Everybody wants to get into that market, we'll begin to see a lot of price pressure. When you have price pressure, it tends to intensify the underwriting. I'm not that sure that you can, because as I said earlier, you're underwriting mild conditions. You could exclude a lot of people who you would otherwise include. Even if you exclude these people, your so-called "absolutely clean" class will have mild conditions a year later. I'll take myself as an example. Last spring was the first time that I ever had sneezing fits in spring. Apparently, there was some new kind of dust in the air to which I was allergic. This spring, nothing has happened. You've got to be careful about who you exclude. It's similar to tossing pennies. You can say that if tails is a bad risk, heads is a good risk. So you've got your hundred coins. You flip them. You eliminate 50 coins. You're sitting there with your 50 heads and you say that you have a super underwriting pool. Lo and behold, what happens? I'm not sure that underwriting harder actually works. I've seen companies lower rates and use this as some kind of rationalization, but we need to wait to see the proof.

MR. ROWLEY: Can I make a comment on that issue? I think that varies tremendously by product line. Having crossed many different product lines, long-term care app completion continues to be the worst I've ever seen. We're not getting the data. So our intensity of underwriting has moved into what Reagan and Gorbachev used to say, "Trust but verify." Don't take the application at face value. We're getting detailed phone interviews. We're getting face-to-face assessments and more and more attending physician statements (APSs) in long-term care and disability income. The intensity in our case is not only to screen out the worst cases, but to find out that the worst cases are there.

For one client, 45 percent of their declines are cases that if the killer questions on the application had been answered correctly would have never made it in the front door. In that case, that's long-term care, the intensity of underwriting, speaking actuarially, does pay big dividends. It probably varies tremendously across product lines.

MR. BILLINGSLEY: The Medicare supplements may be the other extreme in which if you underwrite extremely hard, the only people who will apply with you are those who are coming through up in enrollment with no underwriting requirements. So if you're going to underwrite at all, you need to make sure you're not so strict as to exclude everybody who's possibly going to apply.

MR. DARYL SCHRADER: We seem to be equating intensity of underwriting with more declines. I wonder if there's another way to look at it and if anybody has comments on this. Talk about intensity of underwriting with, say, the degrees of pricing that you're going to be using to recognize differences in some of the different underwriting categories, the degrees of mild conditions, to use Bernie's terminology.

DR. HOLLAND: I'll give you an example in long-term care. A few years ago, cancer was an issue that the industry had this very well thought out, deeply intellectual, zero to three years decline over three years standard, regardless of the type of cancer or the stage. It was a pretty simplified process. By drilling down into having a lot more details — getting the pathology reports or follow-up PSA tests — there are a lot of people who would have been declined, who had low-stage cancer that was found early and treated, that are insurable. It's not just to decline more. We can issue more by finding out which ones are the good ones.

On the other hand, we're not looking at the ones who are the worse stage until five years out or sometimes 10 before standard. You're subdividing it into many categories, which we're hoping are working, but we don't have all the statistics that we'd like. The good thing is that by getting that detail, we can also issue more in some cases.

MR. RABINOWITZ: As Daryl pointed out, it's not an all-or-nothing situation. I was going to go into that later. But very briefly, in the individual business, most companies have a preferred tier and a standard tier. The standard tier is somewhere between a 15 percent and 20 percent grade-up. Companies also exclude medical conditions. In other words, if you're an asthmatic, they will cover everything except expenses resulting from the treatment of asthma, and some companies will rate up. So it's not an all-or-nothing.

When I was talking about the intensity of underwriting, I was talking about putting somebody in the preferred class with no restriction. But there's a lot of competition out there. In other words, what you might rider, somebody else may take standard.

A company needs to be aware of that, and also be aware of what the impact is on the brokers. The brokers are placing cases all over the place. The ideal situation is where you get the right of first refusal. That's absolutely ideal because then you're going to get the best cross-section of risk.

DR. HOLLAND: Also, recognize that products vary on what you can and cannot do. In long-term care, there are no pre-existing conditions. There are no riders because often the disability, the insured event, is multi-factorial. We don't exclude diabetics or a knee injury like you can rider something in a disability product. That just doesn't exist in long-term care.

MR. BILLINGSLEY: There are various constraints on underwriting and they come in various forms. First of all, regulatory constraints vary significantly product by product. Dawn, could you talk about some of the regulatory constraints for the senior health products?

MS. HELWIG: Medicare supplement is heavily regulated in terms of what you can do on the underwriting side. In particular, there's a not insubstantial proportion now of Medicare supplement applicants who have to be guaranteed issue. Anybody who is within six months of first qualifying for Medicare has to be guaranteed issue. That's going back to the OBRA legislation in early 1991. There was some additional legislation in 1996 or thereabouts that expanded the guaranteed issue class to also include policyholders who are transferring into Medicare supplement from some other qualified plan. For example, they were given a trial period of a Medicare+Choice plan. They decide they don't like it and within a year they want to cancel out of it. They can then guarantee issue back into Medicare supplement. Or if they're in the Medicare+Choice plan and that plan folds or they get out of that service area, the person can also guarantee issue back into Medicare supplement. Anybody outside of those parameters you can underwrite. The typical underwriting is generally short form, accept/reject kind of thing. It varies a lot from company to company depending on where their target market is. But if you have a company that is targeting more of the 65-year-olds or the people just as they become eligible for Medicare, there's a small proportion of what you can affect with underwriting.

On the long-term-care side, there are not a lot of regulatory constraints at this point on what you can do with underwriting. There are some market constraints perhaps, particularly when you get into the group market. If the group is of a larger size, it is tending to do guaranteed issue for the actively-at-work enrollees or short form, perhaps, and maybe short form for the spouses. But in the individual market or in smaller groups, it's pretty much full underwriting.

DR. HOLLAND: Competitive pressures are such that you will be spreadsheeted so, as Steve pointed out, good long-term-care sales folks who are representing multiple companies will know where to send their diabetics, their individuals with a history of polio, people who smoke versus people who don't, or someone who's had a history of a transient ischemic attack (TIA) or stroke. You don't want to be known as the

only one that takes diabetics because you'll be over-selected. You also don't want to be known as a substandard carrier because everybody has four or five cases in their bottom drawer that they'll send you. Even though they have absolutely no hope of getting accepted, it just drives your underwriting class.

What people will tend to do is to offer counteroffers, but they don't publicize it; they offer a substandard rate. I do think from a regulatory standpoint, in long-term care at least, it tends to be sales pressure. Issue the policy fast. The holdup is that attending physician statement or medical record. HIPAA has complicated that, obviously, for all of us. It has slowed things down. It has put barriers. That's something the world has to live with.

I would say that three years ago there was tremendous pressure by management and marketing to issue policies fast. I've heard more senior management in the last year say, "Take your time. Get the medical records." I think the actuaries, like Milliman and others, are saying that's very important at younger age groups. There has been a little bit of pushing back on the sales force to not issue things in such a jet fashion in the individual market. Be contemplative. We're going to be here for the long run. We're now under such pressures not to raise rates in the future that we're going to do a thoughtful job of underwriting.

MR. RABINOWITZ: In the individual market, the mantra that we keep hearing from the distribution is that it takes 30 days to issue a case. Companies are now trying to issue cases in 10 days. That's going to become a competitive tool. How fast can you issue cases? Nobody expects a jet issue. We'll get into this when we talk about the underwriting tools. We'll talk about how companies are issuing cases or maybe 95 percent of their cases in 10 days and what they're doing about the other cases that they can't issue in 10 days. This is becoming a big feature in recruiting distribution today.

MR. ROWLEY: I may have said this quote before, but "Trust but verify." I run into a lot of clients who say, "Well, XYZ Mutual did this." If your market intelligence comes from your sales force, it's probably less than ideal. I'm surprised how rarely underwriters will pick up the phone and call the competition.

I have two examples that show how half-truths are being shared. I had a long-term care recently where our client declined because of a fairly recent stroke and was told that XYZ Mutual issued. In this case, I was pretty familiar with XYZ Mutual. It's a fairly conservative company and they could have made a mistake, but I was highly doubtful. I called the chief underwriter there and we had a little off-the-record discussion. In fact, they did issue — six months before the stroke. The agent wasn't lying, but the agent wasn't being totally candid.

Another situation I had was with a disability client who denied somebody and was told that ABC Mutual, a highly respected company that I was also very familiar with, issued. I know these people. They could have made a mistake. They would not have

issued that. There's no way they would have done it. I picked up the phone. They had, in fact, issued — as part of a 500-person guaranteed standard issue (GSI).

What frustrates me is how rarely, when your underwriters are told that so-and-so is doing this, they pick up the phone to find out if that's, in fact, the case. Again, if your market intelligence is coming from your field force, it's probably not the best market intelligence. Encourage your underwriters to pick up the phone. Most underwriters are not going to break confidentiality, but you can learn a lot from your competition. They're not nasty people. They will generally share philosophy.

MR. RABINOWITZ: I want to pick up on this. We once looked at an underwriting shop of a carrier where these people were bending over backward with getting attending physician reports and doing everything possible to take a case because the sales and marketing were right down on them and saying that everybody's doing this. Why can't you guys do it? We looked at some of the cases, and then I called up the underwriters of the companies that were taking certain cases standard where they were going to put a rider on. What I did was I said, "Gee, what do you think of Company A?" That was the first company. They said, "They take cases that we would never take!"

When you're underwriting mild to moderate conditions, there's a lot of subjectivity in it. Sometimes, through a telephone interview, Company B may get that one little piece of information that Company A didn't get. If you take four companies and you underwrite to the most liberal of their decisions, I think you're dead. I think what's happening is that you're taking some of the rough with the smooth because it is subjective. Every time questions are asked, the answers are not always the same. Quite often, different companies are using different underwriting tools.

MR. BILLINGSLEY: Very good. Let's move on to talking about underwriting tools and requirements. Gregg Sadler has been very patient waiting for his turn to speak.

MR. GREGG SADLER: It's no surprise that insurance companies are looking for faster and cheaper ways to get policies issued. We meet with a lot of insurance companies and a lot of them come into our laboratory. We spend a lot of time talking to the companies. We haven't got very many clients who say, "My acquisition costs are just too low and my policy issue is just too fast." I thought I'd highlight some of the data products that are being used. Some of these are being used heavily in the life market. I'm aware of some of them being used in the disability market. I'm not sure at this point about the medical or long-term-care markets; I'm not an expert in those fields.

The first one I'll mention is an electronic prescription history. Of course, prescription histories of an applicant have been used forever in the underwriting process. The more traditional way of getting the information is either through the medical records of the applicant, the application from an agent or a medical examiner

completing a Part 2. More recently, there's a product available in which you can get an electronic prescription history.

Obviously, there has to be an appropriate authorization from the applicant. Once that is obtained, an electronic query is sent to the large pharmaceutical benefit management companies (PBMs). There are a number of PBMs in the country. The largest PBMs have, obviously, a pretty good market share. That query goes to their database. It comes back, and a consolidated report is sent to the insurance company. The report typically lists eligibility periods. Even if an insured or an applicant has not had any prescriptions issued, the result will at least show the eligibility for that applicant. Of course, if there have been prescriptions for that applicant that are contained in that PBM's database, you'll get the prescription, the dosage, the doctor who prescribed the medication, the doctor's specialty and the major diagnostic category (MDC) code, which can be useful if you're running some sort of an automated underwriting system, etc. You'll get a consolidated report of that applicant's prescription history.

The protective value of this product, according to some companies that have done studies, is impressive. I'm going to use a study as an example, with the permission of a company called IntelRx. That's a company that's offering this product. Mark Franzen is the president of that company. He's in the room. He's done a number of these studies for several insurance companies. I'm going to share a couple of samples: one on individual and one on small group.

On the individual, there were 181 submitted applicants who went into the study. On the small group, 200 lives in a small group had a bucket. On the individual side, there were 123 what we call "hits." A hit can be a clear or a returned prescription history. So on 181 individuals on the individual side, there was eligibility information at least on 123 of them, for a rate of 68 percent. On the 200 lives on the small group side, there were 173 hits, for a rate of 87 percent. We've assumed a cost here of about $15 a query. You only pay the $15 when you get a hit, so it's $15 times the number of hits for a cost of $1,845 on the individual side and $2,595 on the small group side. The protective value part comes when the actuaries sit down with the underwriters and work through what underwriting decision changes would have been made had they discovered what was on the PBM query. On the individual side, out of the 123 hits, there were 13 individuals who, according to the underwriters, would have had a premium rate change, and there would have been five declines. On the small group side, there would have been four groups that would have a different rating because of the PBM data.

What was the value of these changes? The insurance company estimated a total savings of $50,000 on the individual side and $82,000 on the small group side. Savings per hit is in the $400 to $500 category, which is a good benefit-to-cost ratio in these particular studies, and there were very significant loss ratio improvements as well.

I'll briefly touch on a few others because these are very quick turnaround kinds of products, which a lot of companies are looking for. In some markets, a motor vehicle report (MVR) can be important. It's cheap. It's very fast, and it can show, obviously, the driver's history. MVRs are also available on a graded basis, so if you don't want your underwriters sorting through all the sorts of violation codes, you can set up a grading system and just have a point score returned and let the underwriter concentrate on the people with the bad driving history.

Another data product that is very fast is the Social Security number and fraud check. This verification indicates if the applicant's Social Security number was involved in previous fraud, if the Social Security number is of a deceased person or if the Social Security number was issued in the last five years (in some situations, that can be suspicious unless there's an explanation on why it was a recently issued Social Security number). The query will also be flagged if the associated address of the applicant on the query is something like a hospital, a penal institution, a commercial drop box, a hotel, a campsite or that sort of thing. If your underwriter is a little suspicious of that particular applicant or maybe a new broker or production source, it can be a quick little query.

Let's move on to the credit information. This is a tool that is also very quick. It can double-check on the applicant's occupation. It's not always the most recent application. It can just be kind of a red flag on that credit history record. It also provides information regarding suits, judgments, liens and bankruptcies, which can be particularly important if there's a doctor or a hospital involved in this lien or judgment. It might be an indication that the individual has had some medical treatment that may not have been disclosed on the application. The credit database is a very large database, and probably 95 percent, if not 99 percent, of the adult population in the United States, are in the database. If you do a query and somebody is not in the database and you don't have a good explanation of why not, it could be a red flag for your underwriter.

Criminal court records are used infrequently, but once in a while they are requested. They're now available in a database form, so it's a very quick query. You don't have to have somebody actually go out to a courthouse, get the records, copy them and send them back.

MR. BILLINGSLEY: Can you tell us about teleunderwriting, one of the new developing tools?

MR. SADLER: Teleunderwriting is now one of the fastest-growing, new business services in the life insurance market. I'm not sure how widely it's used in medical or long-term care, but I know that some disability insurers are using this product. This is a product that has improved dramatically over time. Several years ago, a number of companies did pilots that were less than successful, but with improvements in technology, the growth in teleunderwriting has been enormous.

I'm distinguishing teleunderwriting from a traditional phone history interview (PHI) where the information from the telephone interview ends up on a document, the Part 2 application is made part of the policy and is signed by the applicant. Many companies, including medical insurers, do PHIs. They are very useful pieces of information. Teleunderwriting in my mind is when you actually finish either the application or Part 2 of the medical exam over the telephone. Typically this is a 15- to 20-minute interview, although it can be a little lengthier if you're interviewing somebody, maybe a senior in age, with a long medical history. Some of those interviews can get very long.

The questions in a teleinterview can be tailored by coverages, obviously. For example, details on occupation, such as back problems, would be much more relevant on disability insurance than life insurance. For long-term-care coverages, activities-of-daily-living questionnaires can be incorporated into the interview as well. Insurers report several benefits in the teleunderwriting process. Some of these you also get from the PHI process. Certainly, you get better-quality information than comes in from your agents on an application. In defense of the agents, it's not always the agents who gloss over the information, although the agent's incentive, of course, is certainly to get the policy written.

Many applicants may not be comfortable telling their agents their sensitive medical histories. If your company is doing those interviews and you haven't listened to some of those phone calls, you ought to go listen to some of the phone calls. It's amazing what people will tell you over the phone, information that I can't believe they're going to give to their agent when they're sitting face-to-face across the kitchen table or the office table.
The information is always also very consistent. That is very important because even if you've got a group of agents who do a good job of getting medical information, they're not asking the applicant the same questions. They may be asking the same initial question on Part 2 of the application, but you know that every agent is asking different drill-down questions, if they're asking any drill-down questions at all. Whereas with a teleinterview, right in the program, the interviewers are asking the applicants exactly the same questions. So if you have a thousand asthmatics or diabetics, you know those thousand people were all asked exactly the same questions, which gives you a neat opportunity to stratify risks of those individuals, tweak those questions or change them. They can be changed very quickly.

In the life insurance market, companies report reductions in APSs from 20 percent to as high as 50 percent. Companies that aren't getting very many APSs to begin with aren't going to get a huge reduction in APSs, but there are many companies that have achieved a tremendous reduction in APS ordering from the teleunderwriting process. Obviously, it eliminates the inspection interview on some larger disability and certainly life insurance policies. There has been a traditional telephone inspection that can just be incorporated as part of the teleinterview.

The interview is recorded, which has a tremendous sentinel effect. The applicants know the information is being recorded. I think it helps keep people honest. Even if it doesn't turn out to be admissible in court, which I don't know whether it would in various states, I think that a recorded interview can be an important tool in settling and negotiating a claim even if it doesn't make it into court. Agents like it because it allows them to focus on selling, which is what they do best, not filling out paperwork. Applicants like it because they'd much rather give the information to somebody over the phone in a more confidential setting than face-to-face with their agent. Another benefit is that it's fast. Typically, most interviews are completed within two or three days, and a high percentage are completed on day zero.

MR. ROWLEY: I have one comment on the "agents like it" comment. I have seen that all over the map. My experience is that it depends on the roll-out. If it's rolled out in big companies as, "We don't trust you. You take bad applications. We're going to do this," then it's not going to be well received. The easiest way to win over marketing is to give something to one of them. A company that I've dealt with rolled this out at first to their top 10 percent of producers as a gift because they were so good. The other 90 percent were begging for it. That roll-out was successful. But I've also seen them say, "Your application completion is lousy. We're going to do it over the phone." In one case they tried to cut commissions because they had to take over the process. That failed miserably, as you might imagine. The roll-out, or implementation, is key to the success of teleunderwriting.

MR. BILLINGSLEY: Gregg, you mentioned that the questions can be adjusted and that the application actually becomes a form of application that's attached to the policy. Do the companies that use that generally file that with the state insurance departments?

MR. SADLER: With some states, you do have to file your drill-down questions. Of course, the basic question, the first question, has to match exactly what's written on the state-approved application. The drill-down questions can be quickly changed and quickly tailored. In some states, they do have to be filed.

MR. RABINOWITZ: The way companies are getting cases issued in short periods of time is through judicial use of a pharmacy scan and telephone interviewing, which is different than telephone verification. Since IntelRx was mentioned, I have to mention that our sister company, MedPoint, has a similar product. I just wanted to point out that there are two products on the market.

Now the question becomes, what do you use first? Do you do your drug scan first, or do you do your telephone interview first? The drug scan costs about $11 a hit, and the telephone interview costs anywhere from about $15 to $20 a shot. When you're dealing with mild to moderate conditions, a major indicator of health is the prescription drugs that they're taking. When most people see a doctor, they walk out with a prescription. That's just the way it is in the United States.

If you drill down, you can ask the pharmacy questions on the telephone interview. If you get positives, then you don't need to do your scan. You may want to do your scan on a random basis just to check that you're getting good results on the telephone interview. Alternatively, you can do your prescription scan and see what your hit rates are. By the way, you've got to be aware of false positives because somebody could be clean but that person's spouse could have insurance and they may be claiming their drugs under a spouse's policy. You need to watch out for that.

What's important is to be running tests all the time on a random basis. You first of all do it, and then you run tests on a random basis just to check what's working for you in different areas. One thing you're going to find with the pharmacy scans is that the proportion of people who show up on the eligible list varies by state because the numbers are coming from the PBMs. They are coming from various sources, and there is some variation by state, so you need to watch that.

On the telephone interview, what seems to be happening is that companies that are selling through agents through shops that are using generally unskilled brokers to write their cases will tell their underwriting to get the questions put in on the application. One of the biggest delays, particularly when you ask 93 questions is incomplete applications. At least the applications will be complete.
You've got to ask questions, but the real skill is probing. I agree that you need your drill-down procedures, but a really skilled underwriter or a nurse who's skilled in underwriting, just doesn't turn on a voice, can suddenly just switch and start asking a few other questions. What you're really concerned about are signs, symptoms, consultations with doctors, tests and treatments.

FROM THE FLOOR: Gregg talked about things like fraud and looking at credit information. Particularly with the individual major medical market, how common is that? How expensive is it? Do you have any regulatory concerns with states not allowing it?

MR. SADLER: First of all, you need the authorization from the applicant to get any of the information, presuming that the insurance company would have that in hand. Those products are typically used more on larger life insurance policies and probably disability as well. On the medical side, I haven't seen a widespread use of those products. You asked about the cost; it's about $5.

MR. RABINOWITZ: Driver records are about a dollar a shot. The Medical Information Bureau (MIB) cost depends on what you've negotiated with them, but a year ago it was 60 cents. I'm sure it's more than that now.

MR. ROWLEY: Depending upon the volume, it can be as low as 38 cents.

MR. SADLER: I think MVRs are more like $5. The average handling fee may be $1 for whatever vendor you're using.

MR. RABINOWITZ: If you compare that to an APS, an APS is anywhere from $60 to about $100. You may have to wait a few weeks for it, and sometimes it's incomplete. Sometimes the doctor's handwriting is hard to read. Sometimes the doctor sends you part of his records, and sometimes it's hard to make sense of it.

MR. BILLINGSLEY: We have moved into a general discussion of all the underwriting tools. Let's go back. Some underwriting requirements can be automatic and some discretionary, but the types of requirements include, obviously, a paper, electronic or phone application, APSs and medical examinations. Medical examinations don't tend to be used very much for health insurance, but it's certainly an option to be considered. Other underwriting requirements could be prescription drug records, body fluid testing, phone interviews, face-to-face assessments and background checks. That might be driving records. We've been talking about some of those. Let's talk about how those relate to some of the various products that we work with.

DR. HOLLAND: In long-term care, there are simple rules. The younger the applicant, the less you do. Risk-management information tends to be for cause, something discovered in the application. A lot of carriers now are moving to require medical records at younger ages where in the old days — last month — they didn't. Phone interviews are becoming very important. In fact, several carriers now have added a phone-based cognitive screen to very young applicants. Many of you in this room might even get a cognitive screen if you're applying for, say, lifetime benefits on an individual basis in long-term care. We don't do any body fluid. Prescription drug is not there yet. Face-to-face is extremely important. That's being done at a younger age in long-term care; it's now down to age 70 and some are even going below that. That includes one or two cognitive screens.

One of the largest risks, of course, for long-term care is dementia. This is a condition that's not well documented by physicians because even though there is Aricept and other things, we don't have a good way to treat it yet, so we don't tend to document it in our medical records. We use any way that we can to find that out. Background checks and MIB are not used routinely in long-term care, although MIB is making a movement in. It's a chicken-and-egg thing. You've got to have the data before you'll use it. But if you don't use it, you won't have the data on older individuals.

MR. RABINOWITZ: On the topic of automatic versus discretionary, in the individual medical business it's very important to recognize that a large chunk of your applicants have had a gap in coverage. You can put your applicants into two classes: those that have come off group insurance and maybe are self-employed, retired and have bought individual policies with no break in coverage, versus those that come in and haven't been covered for six months or a year. I believe that each of these categories ought to have its own underwriting requirements, which are

different, because there's tremendous anti-selection coming from those individuals that have had a break in coverage and suddenly feel they need it now.

MR. ROWLEY: I'd like to follow up on one comment Steve made about long-term care. Most of us in the industry right now are basing requirements on age, which is a little counterintuitive to the other industries. If we issue a 40-year-old long-term care with a lifetime benefit, we're taking a much greater financial risk than an 80-year-old with a lifetime benefit. If you compare that to life, then we should be saying that if you get a 40-year-old, you underwrite the heck out of him. Because all it takes is one MS or Parkinson's or dementia claim on a 40-year-old and that's going to do a tremendous amount of damage. What's frustrating for the actuaries and underwriters in long-term care is that we're still making the rules up as we go. The interesting and fun thing about long-term care is that we're still making the rules up as we go. It is a changing industry. The one requirement I wanted to touch on, that as a reinsurer is incredibly frustrating, are the attending physicians' statements. Everyone wants to save time and money. The one thing that tremendously concerns me from a risk perspective and from a legal perspective is, in order to save time or money, allowing the agent or the proposed insured to pick up the medical records from the doctor's office and forward them in. More companies do that than I can understand.

I can tell you that if I write to Dr. Jones twice on the same individual for the same medical records, I'm not going to get identical reports, even directly from the doctor. They'll forget to photocopy this lab page or this office note. When it comes down to going through an agent or an applicant who might see one thing that raises a red flag and if they pull that page out, you're never going to know. In disability, it's very rare. In long-term care, more companies do it than I can accept. It's that chain of custody that the labs will talk about. Did somebody have the ability to tamper with it? If they have, I think you're taking some serious risk by accepting it.

MR. HOLLAND: The reason that a lot of us in the long-term care industry think that an attending physician's statement is important is because we've done studies looking at the source of information. Every bit of data that we collect, we tag with a source. Did it come from an application, a phone interview, a medical record or a face-to-face assessment? We've found dramatically high levels of misrepresentation. Maybe it's just oversight; I'll be generous. But when 25 percent of your applicants under the age of 65 do not admit that they have diabetes even though they're on a diabetic medication or it's in the medical record, or when 30 percent don't mention that they've had a minor stroke or TIA even though it's well documented in the medical record, it makes you very leery to issue a policy to a 55-year-old executive without getting the medical records.

MR. RABINOWITZ: This is why the most important questions on the telephone interview are give me the dates that you saw the doctor, what is the name of the doctor, why did you see the doctor, how were you feeling, what did the doctor tell

you and what treatment did he prescribe? If it's taped, then you could use it as a rescission tool if there was material misrepresentation.

MR. ROWLEY: My understanding is that if somebody says on the application, "Saw Dr. Smith," and you do a phone interview and you confirm that the person saw Dr. Smith in January 2004 for a routine physical, not prompted by any symptoms, all results normal, but you don't amend the application, you cannot rescind. You have to send the interview.

MR. RABINOWITZ: You have to amend the application. You have to.

MR. ROWLEY: Many companies do not.

MR. RABINOWITZ: That to my mind is a mistake.

MR. ROWLEY: Agreed.

DR. HOLLAND: There's very little amending going on.

MR. ROWLEY: Especially in long-term care.

DR. HOLLAND: Yes.

MS. HELWIG: I do want to add one postscript on the long-term care stuff. We have tried to take the experience of various companies — it varies widely — with long-term care and chart that back to what they did in terms of the number of tools that they used (whether they got attending physician statements, did face-to-face assessments, cognitive tests, etc.). The experience of companies that have used those tools and have used them consistently is markedly better. It is so dramatic that it's impossible to ignore.

Medicare supplement is the easy one out of this product portfolio. Generally speaking, on the group of people that can be underwritten, the application is most commonly the only thing used right now. Some companies will occasionally check their own records. If a lot of their Medicare supplement applicants are people who also had major medical with them, they may check the history of their own claims. Occasionally, you'll come across a company that will do more than that in terms of doing telephone verifications or requesting medical records, but that's not as common.

MR. ROWLEY: A requirement we all forget about is checking your own databases. I grew up in the disability field. I thought that it would be pretty routine. I was surprised at a very large disability writer, who also does group disability. Disability over insurance is a huge thing. I was dumbfounded to find out that the underwriters don't look or check the system — they have access to it — to see if the person applying for individual disability has group disability with the company. If they do

have group disability, is there a claim history? We talked about all these expensive requirements that take a long time, but there are companies that don't even look at their own data that they may have on the individual, across product lines. That's the cheapest, fastest, easiest and most reliable data, because it's yours.

DR. HOLLAND: Also, in the long-term-care insurance industry, at least, don't expect as an actuary to be saved by rescissions. They're extremely rare. They always bring bad press. You don't want to see on the front page of your local newspaper an 80-year-old not being able to get into a nursing home because the evil insurance company rescinded her, even though she didn't mention that she was on Aricept when she filled out her application. There are insurance companies attempting to rescind when there's true misrepresentation. But after two years, you have to prove fraud. That's extremely rare, so the post-claims underwriting and rescissions are not strong tools in long-term care, even though some of us wish they were.

MR. ROWLEY: It is very rare but it's on the increase. People have tended to manage claims weekly for fear of being sued and not rescinding. A new lawsuit just hit a long-term-care insurance company by a bunch of policyholders who have been getting rate increase after rate increase after rate increase. They are suing the company for not adequately managing the claims, therefore, causing a rate increase for them. I applaud that. I think it's going to balance the fear of being sued for doing your job with the fear of being sued for not doing your job, which, in the end, might mean people will do their jobs. I don't think it's too much to ask for. But we are seeing an increase in both rescissions and fraud.

MR. BILLINGSLEY: We now have about 30 seconds to talk about costs versus protective value. Cost justification is obviously critical on anything you're going to spend in the underwriting process. There's a sentinel effect, obviously, for any underwriting requirement. If you have told the agents that you're going to do an APS, the agents will tell the client, the client may say that he or she went to the doctor about this condition so maybe he or she doesn't want to complete the application process. Obviously, the cost of the underwriting needs to be factored into the product pricing. There should be verification of cost justification.

You have to monitor the cost. We're all involved in budgeting processes and those pressures exist, so make sure that the costs that you anticipated in the pricing of the product are similar to what you are actually incurring. You have to monitor results by looking at those cases you did take and determine if they were acceptable risks. That's an important element as well.

We came up with a couple of questions for you to think about. I'm not sure that we have any answers. How do you measure the claims that you've prevented? Obviously, that's a tough thing to know. What kinds of risks are we declining that would have been favorable risks? Again, that's going to be almost impossible to measure, but it's something to think about in the cost-justification process.