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Session 12PD

Current Trends in Distribution Channels: New Underwriting for a New Millennium

Track: Nontraditional Marketing, Product Development

Moderator: Juliet R. Sandrowicz

Panelists: James McArdle†
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APSs and fluids are soooo 20th century! This session explores new underwriting criteria including the following topics:

- *What's new in simplified underwriting*
- *Speed to decision*
- *Electronic databases*
- *Teleunderwriting*
- *Prescription drug underwriting*
- *Additional UW as face amounts increase*
- *Results analysis: actual to expected underwriting (meeting your pricing assumptions)*
- *Implementation, processes and workflow*

MS. JULIET R. SANDROWICZ: Our topic is "New Underwriting for a New Millennium." We have a great panel. My name is Juliet Sandrowicz, and I work for New York Life out of the Tampa office, and I'm your moderator for this session. First up today we have Jim McArdle. Jim McArdle is the vice president of alternative markets for Transamerica Reinsurance based in Charlotte, N.C. Alternative markets

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Note: The chart(s) referred to in the text can be downloaded at http://handouts.soa.org/conted/cearchive/NewOrleans-May05/012_bk.pdf.

provide Rx-based underwriting solutions for simplified issue term products to its clients. Jim has been with Transamerica Reinsurance since 2000, serving as the head of its annuity reinsurance product line prior to taking over the alternative markets initiative. Before joining Transamerica Reinsurance, he was head of investor relations for Transamerica Corporation in San Francisco from 1997 to 1999 until Transamerica was purchased by AEGON NV. From 1985 to 1997 Jim held various operating positions with GE Capital and Transamerica Commercial Finance.

MR. JAMES MCARDLE: I'm with Transamerica Reinsurance, and if you've been to some of these conferences in the past couple years, you've heard some other speakers from Transamerica talk about this initiative. You might have heard it under different terms using electronic underwriting, and a most unique item is using the prescription drug histories for applicants.

My perspective is going to be a little bit different from some of the presenters you've heard before. I can't claim any credit for the hand in developing a lot of the intense intellectual capital behind how to use the prescription drug histories and some of the other electronic information to do the underwriting. My role with Transamerica Re is to come in and commercialize this investment in this new paradigm.

We use the automated underwriting for smaller face amount policies. It's a process that we use to identify undesirable risk as opposed to identifying specific people and trying to determine what their exact rating is. As I said before, we utilize electronic underwriting data. It's not just prescription-based information. One of the most important things is this is all invisible to the applicants. They don't participate in a lot of the process behind the scenes, and I'll go into that in quite a bit of detail. It generates quick decisions, which is important.

I'm going to talk about the underwriting platform itself and provide some information on the prescription-based underwriting. I have some slides that compare some of the premium rates to both simplified issue and traditional premium rates. I'll go briefly through some of the work we did early on on the protective value to give you an idea of how we prove to ourselves that this works. I will also take you through some case studies and show you how this underwriting platform would work. That all occurs in a split second, but we'll take you through slide by slide. Finally I'll discuss some of the critical factors that we've learned in making this underwriting initiative a commercial reality.

McArdle slide #3 shows the underwriting data that we use, and we use these underwriting data to decision policies, anywhere from face amounts of $50,000 up to $250,000. This, interesting enough, all started probably about five years ago with the interest. Using electronic information started with the credit information, trying a lifestyle underwriting perspective. We didn't find a lot of value in the credit information itself in determining mortality, but we do use it for fraud or identity checks. One of the things that's important for us is to know who the customers are

and how we can identify them in the various databases that we're going to be hitting. We also utilize a motor vehicle record (MVR). That's another important piece of information, especially at the younger ages. We do have a setup to go into and utilize the Medical Information Bureau (MIB) data. We get information on the application. I'll go through that in a little more detail, and the basis for why I'm here talking is the prescription claim history that we get. All these factors get combined in the underwriting decision to come up with our underwriting outcome.

As can be seen in McArdle slide #4, it all starts with the insurance application, and the application gives us more than just the information on the clients at the time that they're applying for life insurance. One of the critical things to get to comply with the regulations is the authorizations. We don't do any pulling of prescription drug information or any other information until we have an authorization from the customer. In fact, we don't even approach our different data vendors until we have that authorization in the system. That's important, especially given some of the news out there with people's personal information getting accessed unbeknownst to them. It all starts with the authorization.

We also get the prescription drug profile, the MVR, the MIB and some credit data. One of the things that we do right after the application process that's important in our process is quite a bit of prescreening and prequalifying. Obviously there's an expense to get the different data, and if a customer's supplying us information up front that would let us determine that he or she is not somebody we would approve, we don't let it go any further than that. There is some prescreen up front in the applicant-supplied information. We won't necessarily go and get all this information pulled for every application that comes into our underwriting platform.

We have three underwriting outcomes that we work with our clients on, two of which are, obviously, approve and reject. A third one would be to refer. We want to try and save some of the clients that we work with if they don't qualify for a simplified issue policy. We like to take another look at some of them and see if they qualify for another product, or, with some more underwriting, if they might then be able to be approved at a different rate. We basically make three decisions. In most cases it's approve or reject.

Now I'm going to talk a little bit about the application itself. McArdle slide #5 shows the application. It's not the one that we'll be using going forward, but I made it available for a reason. It's a simplified application.

It contains the typical questions, such as some demographic information and some of the health questions. The biggest issue we probably had when we were rolling this out was with some words under Sections C, D and E that say "give details below." One of the things that we ran into that caused us a great deal of turnaround time issues is when we rolled out the initial application. It left a lot of room for the clients to write in information and tell us about their specific ailments. It gummed up the processing. We have now a new approach to this, as we use a

reflexive application. It has eight questions. Six of them are reflexive. We have three levels of drill-downs.

We'll ask a question about a general condition, and if they answer yes, we ask another question that's a little more specific, and then the third question, if they get that far, is the one that's going to determine whether we pass them forward or not. An example of that would be a question on a blood disorder. The specific issue might be hemophilia. If they answer "yes" to a hospitalization question, they're likely to be declined right there. If they answer "no," we proceed. That doesn't necessarily mean they get approved, but we would attach a score to that, and we would continue through the additional underwriting steps. When we first rolled this product out in the marketplace, we went with more of a traditional simplified issue application, which did not work well within the operational aspect of the quick turnaround time. We've gone to a reflexive application.

I'll talk about the prescription drug underwriting itself, which is probably why you're here. We look at the information we get via the prescription drug records in three different ways. First we look for an association of the drugs in the applicant's history that would indicate just by their combination that they're used for a definite treatment or definite illness. The AIDS cocktail drugs would be one example of that. We look for the drugs together. Then we go through another step and look for specific groupings of drugs. One drug may be used to treat high blood pressure and another drug may be used to treat cholesterol. We'll look at what those are used for and see if we can infer that there may be some cardiovascular disease in there.

The final cut is looking at every specific drug with what we would call a probability of treatment associated with a certain disease. There are some drugs that are used 90 percent or more for one particular ailment or one particular disease. We'll take three separate cuts at that prescription drug history and utilize the scoring within our system that has the highest individual score and include that in the underwriting algorithm. As you can imagine, there are a lot of different drugs out there, and there are drugs that are used for multiple, different purposes. We felt it important to look at it in more than just the one-dimensional way, to make sure we're making the best underwriting decision possible.

Whenever we talk to clients and potential clients about this prescription drug information, one of the avenues we always go down is the availability of that prescription drug information. I want to take a couple of minutes to give you a little bit of background on what that looks like and what you would need to keep in mind if you were interested in pursuing some of this underwriting on your own. There's a lot of information you can get from the prescription drug claim history. Some of it is relevant, and some of it may not be. Some important data fields that we use in the underwriting include name, quantity, days supply, date filled, number of refills, drug code, drug label, dosage form, strength, route, therapeutic class, prescriber name, address and specialty and provider name, address and phone number. A lot of them are self-explanatory; the drug code is the most important one. That

identifies the specific drug, which drives a lot of the searching into our tables. There's a lot more information that could be available in the drug history claims.

A number of companies have come in to try and provide the information in McArdle slide #9 to the life insurance marketplace. Some have come and stayed, and some have exited to some extent. To understand the development of the information and where this has come from, you need to know a little bit about some of the players. First are the sponsors. One example would be the company, I suppose, that sets up the prescription drug plan. Next is the pharmacy where you fill your drug claim. Then there are switches that are information companies that play the intermediary role between the pharmacy and the claims manager, which are the pharmaceutical benefit managers (PBMs).

McArdle slide #10 is pretty complicated. One of the most important factors in the success of any prescription drug-based underwriting initiative is finding enough people, enough applicants, to come in the front door. Are you going to find enough of the claims on their histories so that you can utilize the information? If you go and do searches and only find it on half the cases, you're not going to get a lot of value out of there. One of the things that's important to understand is that there are a couple different places you can get the information. Along the right side you see the PBM. We have three large PBMs and then a host of smaller PBMs that represent the good chunk of the coverage. These are the Medcos and the Caremarks of the world, where they manage the prescription drug programs for your company. They're a source of good information. When you get the data from the PBM, if you find the customer, you know that they have a prescription drug program, and then you get the activity. In many cases you'll get value if you find the customers and find that they have a prescription drug program. However, if you don't find any history, that's good because you know they're covered, and they're probably healthy.

The switches, which play the intermediary role, are the processing intermediaries between a lot of the pharmacies and the PBMs. They are exchanging the data back and forth. They have all the connections with the different PBM and facilitate the payment of claims through the system. Information can go through switches and not through switches, and you all can change programs. Every couple years you may go from a smaller PBM to a big PBM, and so it's important to try and have enough places within your data capture where you can feel comfortable you're going to get a good coverage rate. The information that comes through the switches is different from the information that you get from the PBMs. All you're going to get there is the activity. They don't maintain the eligibility files. If you get a hit through a switch on customers, it's good because you have their history. If you don't find them, you don't know that they are on a prescription drug program and have no history or you just didn't find them somewhere. It's important when you have coverage to make sure whatever data source that you're getting your data from asks the questions to ensure that you have some proper coverage.

I will provide some information on some of the underwriting metrics. We do underwriting on policies from $50,000 to $250,000. There is a breakpoint where this pays for itself, as can be seen in McArdle slide #11. On some of the small face-amount policies, such as $5,000 or $10,000, that have low mortality, it's probably going to be difficult to incur, let's say, an underwriting cost of $25 for some of the data in the underwriting processing. But as you get into some of the higher face amounts, it starts paying for itself. There are so many different premium rates on simplified issue policies that it's hard to compare apples to apples, but when we looked at some of the comparisons to some of the premium rates out there, we were able to determine some things. We did a direct-mail campaign, and the results are seen in McArdle slide #12. In the pricing using this prescription-based underwriting versus the mortality you would get with a traditional simplified issue program, we found that you get a substantial savings in the mortality, which will enable you, if some of your other metrics that go into the premium rate calculation are in line, to offer a competitive premium rate on the simplified issue.

We're not stating that today you can utilize the prescription drug information to replace fully underwritten prices. Some of the sample premium rates for fully underwritten products are a lot cheaper, as can be seen in McArdle slide #13. If the client or applicant qualifies for those preferred rates, the QDS (that's our company that does the underwriting) will be a lot cheaper than the prescription-based premium rate. By the same token, it's also going to take a lot longer. The marketplace where we see that this has some legs is that middle market, $50,000 to $250,000, where the customer is not willing to wait four to six weeks for some underwriting but yet wants to have a more competitive premium rate than a traditional simplified issue.

There are a couple of things to keep in mind to get the value out of this. The prescription-based underwriting, this automated underwriting, helps to turn the life insurance purchase process from a long process into more of a transaction sale process. How do you make inroads into some nontraditional distributions such as banks and maybe some nonlife marketplace? A lot of people who are not life insurance agents are uncomfortable with the life insurance underwriting process. We get a lot of feedback from banks and some of the nonlife companies, which are multiline companies that sell life insurance. A lot of the reason they don't sell more is because the agents are more comfortable in the auto insurance world or the home insurance world where everything is transactional. They're just not comfortable with the time and the kind of questions that they have to ask their customers to get them a competitive premium rate for life insurance business.

It's also a customer-friendly process. It's all electronic. They don't see what goes on in the black box behind it. Nobody's sticking needles in their arm or asking them to wait while somebody contacts one of their doctors. It's quick. It helps the companies optimize their resource management. If you can do an effective job in underwriting policies up to $250,000, there's a limited pool of underwriters, and you can redeploy some of your underwriting talent to the higher face amount where

they're probably adding a lot more value. One of the things that's important to companies and especially reinsurers these days is that utilizing this automated underwriting platform enables consistent decisions. The system itself doesn't decide exceptions and considerations and things like that. Also it's a platform to support growth. We've designed systems, and a lot of it is just investment technology that is scalable that can handle thousands of applications. As you see the activity level take off, it's not necessary to keep hiring underwriters and hiring more operational people. Because it all goes through an automated environment, it's scalable.

Let me briefly go back a few years and tell you how we proved to ourselves that this concept has some value. We did a protective value study using about 3,000 simplified issue applications. They were short applications. This went back to a little bit of a pre-Health Insurance Portability and Accountability Act of 1996 (HIPAA) era where you didn't need specific customer authorization. In the study the application had two yes/no health questions; face values of $25,000 to $100,000, with an average of $73,000; ages ranging from 25 to 55, with an average of 42; and a gender breakdown of 33 percent males to 67 percent females. What we found, interestingly enough, is that 27 percent of the applicants that responded "no" to the health question had a nonbenign or bad prescription drug history. Some of the inferences we drew out of that history were some serious potential illnesses, such as breast cancer, renal transplant, rheumatoid arthritis, cirrhosis of the liver, heroin addiction, bipolar disorder, depression anxiety, psychotic disorder, chronic pain, seizure disorder, ischemic heart disease, hyperlipidemia, hypertension and congestive heart failure.

I'm sure you're not all that surprised that people answer "no" to questions whose correct answer is "yes." One of the things we do catch quite a bit now is a lot of people are on smoking cessation programs. We see a lot of people who come in as nonsmokers who are taking some sort of a treatment trying to quit smoking. In addition to that, I would add that more recently we're seeing a lot more that say they're nonsmokers who are actually smokers.

We also did a much larger study looking for the value of this in a traditional underwriting environment. We studied 10,000 fully underwritten applications, with an average size of about $300,000. In the study face values were $100,000 to $500,000, with an average of $312,000; ages ranged from 20 to 59, with an average of 41; and there was a gender breakdown of 63 percent males to 37 percent females. We pulled the prescription drug information after we had done all of the other traditional underwriting procedures such as blood and attending physicians' statements (APSs), and we found that the prescription drug profile would have influenced the underwriting decision in a little over 2 percent of the cases, which, depending on your mortality expense, could be significant. About half the time it indicated an underwriting change. Another half the time it indicated more serious ailments, with evidence ranging from cancer, diabetes and heart disease to mental disorder treatments.

We believe prescription-based underwriting has a role in a traditional underwriting process. It's taken some time for companies to get comfortable with this. I think a lot of the issues seem to have been coverage-related issues. I know companies have gone out and tried to pull this information and have not gotten the coverage rates in the past that they had felt were necessary. I think the coverage nowadays is a lot better than it was just a couple of years ago. Our initiative is not directed at the fully underwritten market right now. We're focused more on the simplified issue, but I mention it because I think this does have value in that area in the future.

I'll go through some examples of what I'm talking about if an application comes in. Let's say we get a filled-out application for a female, age 36, who has answered "no" to all the questions. We would go out and pull the different data, and you can see in McArdle slide #20 that we've got some prescription drug information in the profile. There is nothing serious here, a little bit of a speeding violation and the credit data looks fine. A system would score it benign, as in McArdle slide #21. We would put her in what we call a preferred class. It's a preferred of a simplified issue, which wouldn't be the same thing as a preferred. Don't take that the wrong way. It's in the context that it's in. In this case this person, Jane Smith, would get this policy. We found nothing in the profile. This would be immediate decisioning.

For the next one, let's say we have another female, a teacher, who again answered "no" to all the questions. As can be seen in McArdle slide #24, we found some more information on her that would indicate a little bit more serious type of an ailment: some anxiety and depression. You can see the prescription score there was a little bit higher, a score of 39. She had a little bit in the MVR as well. As shown in McArdle slide #25, we would put this at our version of about a Table 2, and in this case, because the program accepted up to Table 4, she would be approved as well.

The next one is probably a better example of how we catch things. We have a 34-year-old female account executive who answered "no" to all the questions, but we found something serious in the prescription drug profile that would be an indication of breast cancer, as can be seen in McArdle slide #28. There is nothing on the MVR and nothing on the credit, but if you look at the prescription data, there is a score of 90, and that is way above a fail. That would be an indication of a drug that has a high correlation with that specific ailment. Some of the other scores might be a little bit lower, but that would make it a decline.

In the final example, we have a 55-year-old male lawyer who answered "no" to all the questions. As shown in McArdle slide #32, we see something somewhat serious here. There is an obstruction of a blood vessel by a blood clot. There is nothing on the MVR and nothing in the credit data. You can see on McArdle slide #33 that the score is right about a 47, which is getting close to our decline. He doesn't have a good BMI. We would put this one at a Table 4 in our program, and this would be a decline as well.

The way our underwriting programs work is we will approve up to what would be equivalent to about a Table 4 in the underwriting world. We have some clients who, to provide much more competitive premium rate, would only go up to maybe a Table 2. The way the system is set up, it's all score-based so we could just set the cutoff point at the right places.

I want to talk about some of the other factors that influence value in this prescription-based underwriting. Coverage is huge. We need to find the prescription-based information on the applicants. We can get about a 70 percent coverage rate that does vary by state and by location. We watch that as well. Whether you're going to get a lot out of this or not depends on what you're doing today. If you're already doing a lot of underwriting on, let's say, your nonmed type of products, the switchings, the prescription drug-based underwriting platform won't give you as much in the mortality savings as it would in simplifying the process, speeding up the process and hopefully taking a lot of the underwriting costs out of there. If you're not doing much on the underwriting, charging a high premium rate and incurring a lot of mortality, it would be the opposite and would probably take quite a bit of mortality costs out of your current process. When you're looking at this, there's that tradeoff between the mortality costs and all of the other underwriting and processing costs.

There are also time standards that influence value. One of the things that this enables is immediate decisioning. The time it takes to go out and get the different data, with the exception of some states on the MVR, is real time. Our system, if you will, will take the application information in 24/7, and depending upon the availability of the databases (they're not 24/7 yet, but during business hours usually), you can get real-time decisions.

Distribution channel and antiselection are also influencing factors. This is huge. Because this is a different type of an underwriting than the fully underwriting is, we want to make sure we have a reasonably healthy pool of applicants coming through the front door. If we don't, we have a poor group of risks coming through the front door, and we have low coverage ratio on the prescription drug claims. Our mortality's not going to be what we expect it to be. We pay a lot of attention when we're working with clients on what their front end looks like. We've had presentations and meetings with companies like the online insurance services. Some of those meetings get pretty scary when they talk about how they'd like to use this program. We want to put this in the hands of people that we know will go out and give us a reasonably good profile of an applicant. It's through the major distribution channels—targeted direct marketing, the bank platform, the nonlife agency and even the life agencies—although we're a little bit careful with that as well, but that's important as a consideration.

Another important item in this process is the match logic. We want to make sure we find the right person. If we do a search on an applicant and he's in the database but we miss him, it can impact our mortality. On the other hand if we go out and

we pull it on the wrong person, we've pulled a prescription drug history on somebody that we don't have an authorization on, which isn't good either. I talked a little bit about the data availability. That's getting better all the time. It's not yet 24/7, but it's pretty good during business hours and on Saturdays. I think we've got a pretty good expanded time period in which to do this automated underwriting.

MVRs are another operational factor. We can get a lot of them on an automated basis. There are a couple states that have given us fits in trying to get the data electronically. This works well if you get all the electronic data at once, but a couple states will not let you do this on an automated basis, so there are tradeoffs. Do you not get the MVR and have the quick underwriting process, or do you bake in additional mortality because you're not going to be able to get that? We will make that decision with the client.

Among the key factors or learnings is the application is important in terms of the quick process. You should have a reflexive application with decisionable drill-downs and no text. One of the things that we always run into is clients who want the electronic application and then say, "Oh, by the way, but we still need paper for all our agents." That's a difficult one to deal with, and we've tried to blend the two, but we found it's much more effective to have a completely separate process for the paper applications. Paper applications just cannot go through on this kind of automated platform. The up-front edits and screening are important, too, making sure that the information is in the right place and is accurate before it gets to the system and before we do the scoring.

MS. SANDROWICZ: Next up is Ernie Testa. Ernie has more than 30 years of experience in strategy management, customer service and operational capacities within the insurance industry. He has had extensive experience in new business and underwriting policymaking, product development, operational management and business process design. In 2000, Erie founded ATSET's Consulting Group. It's now ATSET Solutions. This company performs information technology and management consulting. Ernie is president of the firm and over the past several years has been advising multinational corporations (in the U.S., Canada, Europe and the Caribbean) on assignments ranging from developing operational and organizational strategies, business process design/redesign and customer satisfaction surveys. Ernie is an associate of the Health Insurance Association of America and holds a Certificate of Proficiency from the Academy of Life Underwriting. He is past president of the Home Office Life Underwriters Club of Greater New York. He has served on the executive council of the Home Office Life Underwriters' Association and was elected the association's 60th president. He has held the position of chairman of the Finance Committee for International Underwriting Congress. He served on the board of Gibraltar Laboratories. He has served on the ACLI's Privacy Committee and Risk Classifications Committee. He has written extensively on a variety of risk classification and management topics. His articles and commentaries have appeared in the *Journal of Insurance Medicine* and Life Office Management Association's (LOMA's) *Resource* magazine.

MR. ERNIE TESTA: I'm going to be talking with you about a number of issues. I'll talk a little bit about the background in our environment, what's driving a lot of the change that's happening. We'll talk about process workflow and speed. Is speed all that important? I'm going to talk about teleunderwriting, which isn't so new anymore but is certainly picking up speed in the individual life insurance product underwriting arena. I'll also talk about what's next in higher face amounts. As the amounts of insurance go up, what will we do next?

I'm going to talk a lot about the customers, the men and the women who pay the premiums for the products that we sell. I'm going to discuss what we do to them in the process and how we may need to behave and act differently in our processes and in the way we interact with them. Actuaries are not facing off with customers, but I give my actuarial associates a lot of credit. They understand the need of what they do and how it impacts the customer. If there is a person or two out there who hasn't realized that yet, let me be the first to tell you the days of the silos are over. It's no longer an environment where the actuaries do their thing, the underwriters do their thing, and the sales people do their thing. We all work together to try to satisfy that customer out there because other organizations and other business sectors are taking the customer away. You may not agree with everything I'm going to say, and that's okay. I want to challenge you. I'm going to throw it out there. If you want it, you keep it.

The traditional client acquisition function is labor-intensive, slow and costly. The speed required to do business in the 21st century requires radical redesign and effective automation of the traditional business processes. What I mean by radical is there have been a lot of changes that have taken place in individual life underwriting for the client acquisition process. When I say the client acquisition process, I want to look at the process end-to-end, not just the underwriting function. When I say client acquisition, I'm referring to the moment from which the customers decide they want to buy the product to the moment where we put a policy in their hands. Radical? I think we made a lot of changes, but they've been more tactical than major to address a process that was probably a business model designed 50 or 60 years ago, or maybe even longer ago than that.

I want to explain effective automation. We throw a lot of automation at the process, but I would say that much of it has not been effective. Although you will read articles and hear presentations from people about what they're doing with technology in their environment, it may not necessarily be exactly as you're being told. Here's a little more reality: "The insurance business will change more in the next five years than it did in the past 50 years." I don't make this stuff up. I may have abbreviated or edited some of these comments, but these are things that I pick up from various industry and trade publications. This is what people are saying. "It took more than a century to entrench and establish the old insurance leaders; it will take less than a decade to establish the new ones." Most important, "In the 21st century the life insurance technology industry will focus less on insurance and more on business processes." This is the essence of what I'm going

to talk about—the business process, the way we interact with our customers and the way we interact with agents.

This is the real world. For a project that we did about a year and a half ago, the average was 54 days from application date to delivery of the policy. That included five days getting the application to the head office, two days beginning to review the case once it was received, 16 days waiting to get all underwriting requirements, three days making an underwriting decision once the last requirement was received, nine days generating a policy and mailing it to the agent and 19 days to deliver and place the policy. I believe LOMA did a similar survey and tracked almost exactly the same amount of time, and I think there were 50 or 52 days. It's taking us too long. This company called us in and wanted us to focus on reducing the cycle time in the underwriting process, and we said that it's not going to work well.

Even if we can get 30 days down to one hour, you still have five days on the front end and 19 on the back end before the customer gets a policy. That's nearly 25 days. You haven't accomplished a lot, looking at the process from end to end. If you simply want to get your commission paid to the agent faster and reduce some of the noise level that agents may be creating in your environment because underwriting is taking too long, by all means just focus on that middle piece. But if you want to focus on your customers and make sure that they get the product for which they made a prepayment; went through blood testing and urine testing; and completed multiple forms, multiple signatures and other requirements, you need to look at it from beginning to end.

The future is all about FCB, which stands for faster, cheaper and better. We need to become much more efficient and cheap in the way we process. I don't mean introduce less quality, just less cost. Our cycle times are too long. Our costs are much too high. When I talk about increased productivity, I'm talking not just about the underwriting environment, but also about the sales environment, the post-issue and all of the other functions that are part of the client acquisition process. I'm talking about a much more desirable experience for our customers.

It's all about process. Incremental process changes, in my view, have added more complexities to the process than anything else. An example would be of a company where once we did the initial analysis, and it became obvious that one of the steps it had included in its process was that it needed to have the agent complete an age verification form with every application that it submitted. We found that in nearly 60 percent of the cases being submitted, the age verification form was either not included or was not properly completed, so it was spending an inordinate amount of time going back and forth trying to get this age verification form completed properly.

We asked why it needed an age verification form, and there was no easy answer. We asked it to go back into the company's record and try to track this down. The company found that back in 1938, it implemented this procedure because a large

percentage of its claims required recalculations because the age at the time of application was misstated. To avoid the problems associated with recalculating the premiums, values and dividends, which was a manual process at that time and a laborious one, it said it was going to require an age verification form with every application. This was 2004. I don't think the process of recalculating an age misstatement is quite that labor-intensive anymore, so it was a matter of taking a look at it and asking whether the age verification form was necessary any longer. If we only focused on the underwriting process, we would not have achieved the level of cycle time improvement that we were able to achieve by simply doing away with a form that was no longer needed.

Most attempts at all electronic applications have failed simply because most people have taken the old traditional paper application, and they've put it online or on the agent's laptop. My simple question is, If you can get your agents to complete the paper form, what makes you think that they're going to complete an electronic form? Transferring data entry functions down to the agent level is not necessarily the way to go. The bottom line is most people that have migrated to an electronic application format that represents the old traditional paper form. They are printing it and processing the electronic application as paper.

Rules engines have not made underwriting easier. There's a tremendous desire out there to try to get straight-through processing. Unfortunately our business doesn't work that way, but rather than looking at straight-through processing from end to end, the advice that I will give you is to look at engines that are able to mechanize some of the process and then only expose human intervention when there are exceptions type of activities. Technology hurdles still exit. Yes, there's a lot of old brittle technology out there that unfortunately is being layered with newer technology, but it is not effectively integrated.

I will discuss typical process workflow design flaws. Again I will restate that focusing on the underwriting only may not necessarily be the way to go if you want to improve cost efficiencies, cycle time and the customer experience. Look at end-to-end processing. Not leveraging operational costs is a way of balancing mortality targets. What do I mean by that? If you're spending $100 to save $2 worth of extra mortality, it may not necessarily be the way to go. Beyond that, most people that I've worked with tend to look at break-even analysis. Let's talk about attending physician statements (APSs), the medical records. They typically will look only at the cost associated with getting the records, meaning what they pay the attending physician or the hospital facility. They will try to do a break-even analysis on that cost. You need to dig down much deeper. The cost associated with ordering those records and processing them once they're received needs to be in the equation. When you look at the actual cost of that APS beyond what we simply pay the doctor, you will find that the break-even analysis takes on a different set of characteristics.

One typical flaw is to be internally focused rather than externally focused. We need to find out what customers want. I'll use another example. A number of years ago we did some customer focus groups to try to find out what were customers' understanding of the product illustrations that were being provided. We invited recent policyholders who had been sold a policy with an illustration to various hotels. We served them a breakfast or something and had them provide us their feedback. The facilitator for the sessions at a meeting in Boston provided each of the participants with an actual illustration. Customers were looking at it, and one nice gentleman was shaking his head. The facilitator asked, "Would you mind sharing with the rest of the group what you're thinking? What's on your mind? Why are you shaking your head?" He said, "I remember the agent giving me this thing, and I looked at it, but I don't understand any of it. There's so much stuff: so many numbers. You've got to have a Ph.D. to understand this stuff." At the other end of the table, a gentleman piped in and said, "I have a Ph.D., and I don't understand this stuff." That sent a powerful message to me and the rest of the group as to what it is that we're giving our customers. We're giving them a lot of stuff, but are we helping them to understand what our function and what our products are?

Most of what's been done over the past 20 years has been pretty much from a tactical approach. I think the new paradigm in underwriting needs to be addressed from a strategic perspective, focusing on a better way of conducting business, redefining what the customer service/delivery needs to be and changing the nature of the risk and embracing costs and our operations' managements. We do some call center work, and one of the things is that in the call center environment everything is measured. In fact, in some state-of-the-art call centers, if you can't measure it, it's probably not worth doing. When we look at the underwriting environment or the insurance environment, per se, we don't have the measures and metrics that are common in the call center environment. Granted, they may need to be different kinds of measures, but we need to know exactly what we're doing not only from a mortality perspective but from an operational perspective so that we can define exactly what the cost, cycle time and improvements are and need to be.

That gets us to teleunderwriting. Teleunderwriting is a way of conducting business in a better way. What is teleunderwriting? It's a new process that was developed probably with some earlier companies going back as far as 10 to 12 years ago where either underwriters or trained interviewers will gather risk classification information directly from the client over the telephone, thus teleunderwriting. It isn't underwriting done on the phone. It's just the telephone being used for gathering underwriting information. It changes the nature of the risk, and I'll come back to that in a moment.

I want to try to demystify some of the issues about teleunderwriting that people are talking about. Harry Woodman, an actuarial friend of mine, was also president of the Home Office Life Underwriters' Association, and in his presidential address he stated that when it comes to underwriting, everyone is an expert. I'm beginning to see that when it comes to teleunderwriting, everybody seems to be an expert these

days. There are people out there who are yelling almost in an evangelical kind of way about the benefits of teleunderwriting. I want to try to put it into perspective. Teleunderwriting does not reduce APS rates or improve cycle time. The reality is that if you want to improve cycle time, and you want to improve the number of APSs that you're ordering, you need to redesign and address your workflows and handoffs, and then you've got to take a look at your underwriting guidelines and your rules.

There is no question that through a focused interview process, you can eliminate unnecessary APSs. I'm going to tell you what I mean by unnecessary APSs. As an underwriter, I will get an application, and there is a citation completed by the agent that says "Checkup for colitis two years ago. Okay now." I don't know whether it's okay now and it was colitis of the ulcerative type, which carries substantial extra mortality associated with it, or maybe it was the spastic kind where you took some Pepto-Bismol for a couple weeks, and the applicant's okay now, but the bottom line is I've got to go out and get those medical records. And 99 times out of 100 the answer is going to be it was the kind that was taken care of by a little bit of Pepto-Bismol. I spend money and several weeks waiting for the medical records. Through a teleunderwriting interview, you can eliminate the unnecessary APSs, but certainly you're not going to eliminate APSs to the extent that some people are talking about it. That gets our reinsurance friends a little excited, and we'll talk about our reinsurance friends, as well.

One big myth is that teleunderwriting is just like a telephone inspection or personal interview. Absolutely not. There are a number of companies out there that offer teleunderwriting services where you can outsource your functions to them. Some of them do a good job, and some of they may not. I would say if any one of them tells you that the teleinterview is the same as a personal history or an inspection interview, you probably should run away from them because these are the discreet differences between the two. A bigger myth is that teleunderwriting will cause too many problems with our agents. That is absolutely untrue. Most agents that we work with and talk to look forward to a teleunderwriting environment because the reality is that it frees them from the mundane kinds of duties that we have imposed on them that go beyond their primary function, which is to sell and service customers. Once they understand what the change is all about, they become the best cheerleaders for a teleunderwriting environment in the organization.

Another myth is that it's unprofessional to have underwriters conduct telephone interviews. Get over it. Another big myth is that teleunderwriting requires minimal investment in new technology. That is absolutely not true. It will require substantial investment in new technology, but it can be done in phases. Just be sure that you address your business and functional requirements and that you are particularly and acutely aware of the functional requirements, where you're creating touch-points with your customers. Those are the Day 1 requirements that you need to have, and you can put aside the nice-to-have items for the next phase.

A colossal myth is that the reinsurers won't let us do it. This is simply an excuse for people who don't want to change. Reinsurers are not opposed to teleunderwriting. It is a fact that reinsurers are more concerned about your achieving the mortality that you price for and the rates that they're charging you. But at the end of the day, they are our partners, and I think if we bring them to the table and they understand how and why we're making the change, not only will they partner and buy in, but I think they will provide good input to us because they're out there working with many companies and understanding a lot of the changing environment. By the way, we are not currently engaged with any reinsurer. I'm not being paid to tell you this, but I would say that probably over the past five years more so than ever before, reinsurance has become the whipping boy for anything that's going on out there.

The biggest myth of all is that mortality will suffer. The cornerstone of risk classification is the sentinel effect that a mere requirement creates. In other words, that will keep some people from being dishonest. It will work toward people giving us all of the facts, and, in some cases, keeping people from applying to us in the first place. The sentinel effect in a teleunderwriting environment is not lost at all. I would argue that it is enhanced because you are now taking the most critical function, the gathering of the risk information, out of the sales process and moving it into a centralized environment by trained personnel who are going to do it consistently and effectively all the time.

I don't think anyone can give me 100 percent assurance today that your agents or even your paramedical vendors where you're getting a paramedical exam are asking your customers 100 percent of your risk questions 100 percent of the time and in the same fashion with the same intensity and degree of drill-down. In a teleunderwriting process, I would argue, you can be assured that that is the way your business is going to be processed. What's the value of knowing that 100 percent of your customers are asked 100 percent of your questions all the time? I think there's a value there. I don't know what it is, but there's a value, and it changes the nature of the risk.

In the old environment, as an underwriter you receive the information. If the information was marginal, inaccurate or inappropriate, you didn't know whether the agent did a poor job of gathering the risk information or the customer was trying to withhold information from you. Now you're dealing directly with the customer. The agent is focusing on the sales function and servicing the customer. You're focusing on gathering the risk information. You know that if the information is inaccurate, you're dealing with a customer who is not being forthcoming with you, and you can take the appropriate steps. It creates an environment where the information is much more credible. The bottom line is that it's a faster process. It's an efficient, credible process and is a more customer-focused process because we eliminate the redundancies of going back and forth to the customer for clarification and additional information.

That leaves me with my last point. What will we do with the amount of insurance going up? This is what we have typically done in the past. We've gotten more stuff. This is pretty much what we do today, and I'm not sure how much more we can impose on our customers. I think if someone asked 10 years ago whether you can do what Jim is doing at his company, most people would have said, "Absolutely not. It'll never work." Well, it's working in his company. I think we need to make more effective usage of information. I'm not suggesting we do away with all of this, but we can trim down some of this. However, we have to look at different ways of gathering and obtaining the information necessary to make the risk decisions. Looking at databases, the MIB in particular, is an area where you can access data in real live time. In a process that we redesigned, we added the actual teleinterviewers having the MIB information dynamically before they began the interview, positioning them in such a way that if customers had a medical history that they were not disclosing, they now knew that there had been a record and could use that information within the guidelines of the MIB to further drill down on the specific history.

What do customers want? They want a desirable process experience. They want to feel good about doing business with us. All the surveys nowadays say that customers don't feel that way, and, by the way, they're going somewhere else to buy their financial products. They want simple processes that they do once and are done with. Underwriting and life insurance are not once-and-done processes, but we've got to find some way to integrate the steps and make it a bit easier for them. Flexibility is something else they want. I have a quick story about bankers. I don't particularly think they're terrific managers, but they are good process people, yet they took the concept of an ATM and positioned themselves in an effective way. It's nice for us to be able to get our money any time we want, 24 hours a day, but the reality is the bankers didn't do that simply to satisfy our needs. They did it to reduce their cost. When we talk about making it better, more flexible and easier for the customer, it doesn't necessarily mean it's got to cost us more. In fact, not only are the bankers having us do the work that they used to pay to do, but you go to some ATMs and you're paying $2. They're charging us. The bottom line is that they're making money anyway.

MS. SANDROWICZ: Last up is Vera Dolan. Vera is a consultant who specializes in life underwriting research, life underwriting manual development, product development and pricing and insurance management consulting. She started her consulting firm in 1989 and since then has assisted many clients, including Canada Life Re, Clinical Reference Laboratory, General American, MetLife Canada and Wells Fargo Bank.

Before Vera began her consulting practice, she performed research and analysis for Lincoln National Re and Transamerica Occidental. She also served as a medical economist for the Kaiser Foundation Health Plan, where she facilitated the conversion of community-based rates to experience-based pricing.

Vera has a B.A. in public health from Johns Hopkins, and an M.A. in epidemiology from the University of North Carolina at Chapel Hill. She is a fellow of the Academy of Life Underwriting and a certified editor in the life sciences. She is an associate editor of *On the Risk,* where she has contributed dozens of articles for almost 20 years.

MS. VERA DOLAN: I took a look at the past surveys done on simplified products. The last time a survey was done was for the annual meeting last year in October. It was performed by the Committee on Life Insurance Mortality and Underwriting Surveys. It comprised 27 companies and 48 products, which were their top one or two selling products. The information was collected by pen and paper in August 2004. It was presented by Al Klein and Mark Swanson at the meeting last year in October, and you can get the transcript and slides of the summary of that presentation on the SOA Web site. The final report is in progress.

I wanted to do something a little bit different to complement the study. I was asked to do a couple of things, and I found 21 companies willing to participate in my survey,10 overlapping from the previous one. It comprises 31 products, essentially the top one or two sellers. Remember that the products that I'm going to be talking about are the ones currently selling. They don't necessarily represent the most cutting-edge technology, but just reflect what is working in the market. I figure that there are a lot of good things to learn from what people have already done. My mission for this presentation is to focus on the use of underwriting resources and focus on experience today. The final report is going to be sponsored by MIB and should be out by the end of the summer. Before I go into the actual results of the survey, I want to first thank the people who helped me outreach to the study participants, and they include Juliet, Ian Duncan, Carl Crawford and the sales team at Clinical Reference Laboratory. I also want to thank the survey respondents who spent their time talking with me on the phone. Some were constrained by their own needs to keep things confidential, but others were forthcoming in telling me all about the things and lessons that they have learned so that we can all benefit from that information.

I want to start off with the bottom line. What can kill a product? Worst cases happen. In your wildest nightmares they do happen: "We had our clocks cleaned." "Some claims arrived before the policies were issued." "Brokers gamed the system by disclosing only with the limits set up by the application—if the myocardial infarction happened one month before a 24-month limit, the case was submitted. We had limited ways to check history." "Brokers didn't care whether they still had a contract with us the following week." :"We lost control of the risk assessment process." "If we were to do this again, we would use a channel that is more controlled, but we would never do this again." These are the words from people coming from a traditional background, dipping their toes into the simplified product market and thinking that they can just jump in and not understand what the simplified product market is.

Let's talk about the next level up, the people who are doing better in the simplified market. They say things like: "Our mortality ratios have been running close to 100 percent for the past few years." They were doing okay but had pressure from their channels. Another thing they were saying was, "Agents tried to talk us out of using MIB, but we refused." Another is "Agents tried to talk us into changing our age and amount limits, but we refused." There's also, "We had low volumes until our agents started marketing more aggressively." The take-home message is that channel is going to make or break your product.

Let's talk about the people who do well. Most of them have been the people who have specialized in nothing but simplified products. They are saying, "Our clients and agents are happy, and we are extremely pleased, as well," which is shorthand for "We're making money, and we made a solid long-term commitment to this market and devoted the necessary efforts and resources." They did their due diligence and went into it with their eyes open, just like you. Another thing they are saying is, "We kept close control of our agents, including random audits of their business." That was their method of the sentinel effect for their agents.

Let's discuss the markets you are into. First, there are the untapped ones, such as banks and mortgage sellers. Next are the underserved markets, such as the older ages, either for final expense or afterthought. They are the ones who neglected to get their insurance when they were young and healthy, who find at the end that they do need insurance of some sort. Rather than go through the whole traditional process, simplified products offer them a good way to get what they need. Juveniles are also part of the underserved markets. The people who specialize in the juvenile niche don't necessarily make their money off the juveniles, but rather, it opens doors to the agents who can get down to the kitchen table and then sell to moms, dads, grandparents and others like that. That's where they make their money. But juveniles is an excellent niche for simple products. A third underserved market is low- to middle-income families. They've been somewhat ignored by agents because there's no compensation for them relative to what they're used to in the higher markets. However, this is still an underserved market. They need life insurance as well as anybody else. Simplified products are an excellent fit.

The next market is filling the life gap for the property and casualty (P&C) people. This is an excellent way for people who know nothing about life insurance to round out their customer service. For P&C people, simplified products are a no-brainer, and that's exactly what you want. Another good market is the corporate-owned life insurance (COLI) area. Simplified products are excellent for groups in which there may be a handful of individuals who have sufficiently worse risk and might bring the whole group pricing down. What you want to do is carve out those people into a simplified product. It's not as onerous as the traditional product, but you still have a different product going into a different pool; it's just simplified. These people don't feel singled out. COLI carve-outs are an excellent place for simplified products.

I want to talk about the attractions of simplified products for people who are not quite in that market yet, who are coming from a traditional background. It means a new source of premium income, a new source of policy value, expanded service of core markets, expanded services for distribution channels and reduced underwriting expenses for those who want to do that.

When you are doing simplified products, there are issues that you have to think about. You want to decide whether you want to expand your traditional workflow or start all over with a dedicated operation. You have to consider what your channel outreach type and strength are. You need to figure out what your market prequalification control parameters are. You need to design your product, and you need to decide whether you're going to stay with an internal shop or outsource some of your work. You have to decide where software leaves off and people start taking on the work and which electronic databases to use.

There are some trends to notice, and this is what I got from the survey. Dedicated operations appear more successful. These tended to be the more mature operations, and they were the ones that invested in a lot of service dedicated to the simplified product. Banks' glitter is not gold. If you're passive, you can't just put brochures out there and expect it to sell. You have to put some effort into it. With your bank and mortgage partners, you're going to have to get some marketing programs together. Keep the reins tight on distributors. Don't let them wander the intensive care units looking for prospects and forget preferred. Preferred is not even part of the scene here because you're not getting the kind of requirements that would lead to a preferred product. If you were underwriting traditionally, what would be considered standard in a traditional way would be standard to Tables 2, 3, and 4. One company even went up to Table 6, all in one category that it considers to be standard.

Internal resources are great. If outsourcing, according to my respondents, you have to find the right partner. When you've got a good partner that is aligned with your goals, it's great, but if there is a conflict or it doesn't get it, it can be bad. Qualify your outsourcers. Human touch is best carefully planned. Don't just say, "We're going to get these people just to leave off where the software takes on." You have to think about it. As Ernie said, look at your workflow, look at how things are going, and then go from there.

I'm going to discuss product design. Don't do anything fancy. For those who get excited by fancy products, this is not the field for you. Use basic riders. Not even all of the products had riders. They're just spouse and child, accelerated death benefit, waiver of premium and accidental death. This is basic stuff, and tiny loads for compensation in underwriting. Basically what you need to do is focus on your strategy, on how your whole system is put together and on how it works. You don't want to second-guess yourself at the end.

Up front you want tight limits on your age and amounts matched to your target market, matched to your application questions and matched to your underwriting resources use. If you are doing a niche market, one size does not fit all. No one allows exceptions to risk class. One of the people who had a traditional background said thank goodness that no agent is calling up to ask if we can get someone into preferred. You don't have to worry about that. That's one less headache, and that's why he was happy about being in the simplified business. If people are outside the limits, it's decline or pass to fully underwritten product.

The people that I talked to ranged from one to 45 years, with a median of 11 years. There was a lot of experience in here. We took the top one or two products. Almost half were term. Almost a third were whole life. There was little complicated stuff like universal life, guaranteed issue (GI) and variable. You can see in Dolan slide #15 that I have the child niche and the elder market niche there, but median covered what we would have as traditional, as well. The accepted amounts were low as can be seen in Dolan slide #16. These are the COLI carve-outs, but the median were still far lower than you would get in a nonmed market.

As far as the resources used go, MIB was the top one for all cases. There was even a reflex to MIB, which was 4 percent. The "never" category amounted to 14 percent (juvenile and GI). When it comes to underwriting resources used for outsourced personal health interviews, for all cases the amount was 8 percent, with reflex being only 19 percent and never being 73 percent. Again, these are current generation products. A lot of the newfangled stuff hasn't been coming up. For MVR, resources used for all cases was at 8 percent, reflex was only 27 percent, a random sample (as audit) was 4 percent and never was 62 percent. With APSs, I was surprised to see that 69 percent were reflexed, with never being 31 percent.

When it comes to underwriters still in loop, they were still internal traditional underwriters. Fourteen percent were on all cases. Sixty-four percent were reflex only. Outsourced underwriters were overflow only. Teleunderwriters were not used in this generation of products. I expect that that is going to change sometime in the future. There are also electronic databases. Looking at the pharmacy database, currently for the top selling products it's not being used widespread, coming in at 8 percent for all cases and 4 percent for reflex only. Also, the consumer credit database registered at 4 percent for all cases, but plans are in progress with a lot of these companies to update or develop products surrounding these. I will talk about two pharmacy database experiences. One was an experience. The other was a study. I want to caveat that this was from older ages only, so don't think that these results apply to anything other than the older-age situation. This was a final expense product.

They had difficulty with early claims and antiselection. Their agents were probably cruising hospices for their products, and don't let your agents do that. Legal said that they could not contest the dementia cases that were showing up in their book of business. They didn't want to tell me about how it turned out for their incoming

business, but they did say that only five out of 16 claims had database hits. That is too few for reliability.

Another company shared with me its older-age market. It got too few hits to justify costs. It found that its PHIs were better. Some cases took days, not minutes, to turn around. Just like the MIB, it could not take an adverse action for contract. It had to use this as a red flag but then do further investigation. The person I interviewed who did the study said to check this out for younger ages, higher face amounts and claims investigations.

I want to talk about process design. Dedicated operations build their own. There's no legacy. To overhaul or adapt operations, they just changed the underwriting process. They weren't listening to Ernie. They just dropped their product into the traditional workflow. Their software decided whether they could bypass or reflex to an underwriter, and most of the heavy-duty work was done by a traditional issue clerk.

Finally, I want to say a few words on reinsurance. Their reinsurers were not always involved. Just a little over half of the survey's products were reinsured, but when reinsurers did participate, it was mostly first dollar, and it ranged from 40 percent to 90 percent, with a median share of 70 percent.

MR. CHUCK RITZKE: I have a couple of related questions. Jim, you mentioned being able to use this reflexive application to filter out applications before you got to the point where you ordered all the data and stuff. If you're doing an accept/reject kind of underwriting, do you have any feel for what range the percent that you might be able to filter out before you get to the next might be?

MR. MCARDLE: It's probably no more than 10 percent.

MR. RITZKE: Somewhat related to that, you mentioned a 20 percent potential underwriting savings over a traditional simplified issue. How much value, if any, might be added by combining the process of doing an electronic reflexive-type application, an underwriting interview and, maybe as a kickover thing, that would be based on what information you find at the first stage?

MR. MCARDLE: I think you just have to be careful not to mix two different programs in trying to do that. We utilize the reflexive application to try and get information in a decisionable format for the smaller face amount policies inexpensively. We've been down a road like this with a client. We were working on accept/decline and then looked to refer a bunch of these for somebody to look at it to determine if it made sense to underwrite some more. The client was adamant up front that it wanted to do this. Why lose a potential customer? By the time we got down into the analysis of the dollars and cents and what percentage of those applications that didn't pass would turn into policies under another program versus

the cost of handling all of the referrals, it ended up deciding not to go through that third criterion and just stick with the accept/reject.

If the customer's willing to go to a higher face amount with this alternative process, the higher premiums and the higher margins on the higher face amounts may be able to pay for some of this. But our experience has been, again, in the narrow range of what we're looking at, that accept/reject is the most efficient way of doing it. You need to be careful on your costs when you want to try and save potential customers and turn them into another underwriting area.

MR. TESTA: I agree totally with what Jim said. I would only add that I think you could take the model that they have, which is obviously for a specific product, and begin to utilize that model to build on in a traditional individual life underwriting environment. In that environment you're going to be processing some at some level and some specific markets at some specific amounts through some kind of technology that enables you to do the initial screening and then pass to the next level. To further clarify my comments about electronic applications, for any model that we ever worked on, an electronic format is the fastest, most efficient and least expensive way of getting information from point-of-sale to where it needs to be for processing. My only comment about the less-than-successful experience people have had is that it is because they've never focused on what the level of information they need to have at point-of-sale is to begin the process. They simply took the old application and made an electronic form.

MR. RITZKE: You mentioned preferred underwriting, and that it's not the same as the preferred that you see. I was wondering whether you had a feel for what range might be feasible in terms of defining a preferred class, where it would make sense to differentiate and what that differential might typically be in this kind of environment based on the kind of information you collect on the application and the data.

MR. TESTA: We are not employing a process in which we believe we can tell the individual applicants when they come through the system what their specific correct underwriting classification is, as you would if you got blood tests and APSs and everything. We're underwriting pools. What we try and do is get a reasonably healthy pool of lives in the front door, and through our electronic underwriting and our accessing database, try and exclude the bad risks and leave a much better profile of risk that we appropriately price. Conceptually that's what we're doing.

I regret even leaving our preferred underwriting tag up there because we'll get some customers who may be preferred only in simplified. But they like the simplicity. They like to be able to get this policy right away. We'll also get some for whom we don't find prescription drug histories, and they're higher than Table 2 and Table 4, but looking at it as a large group of applicants and underwriting the pool of risks, that works for us. At this point I can't tell you it'll be just a matter of time before we say we'll be able to get a few more pieces of electronic information, and

we'll be able to underwrite a preferred risk just like you might do today with all the blood work that you get. Maybe some day we be able to do that. That might change if other information became available electronically. Some of the health information that's being talked about now is making more of that information available electronically. If you have an infrastructure and a platform that can process that, and that becomes available, you might be able to get access to some of those diagnosis codes. If you could, you may be able to do that. But with the information that's available now, this is conceptually the way we're underwriting these pools. I wouldn't say that any time in the near future we'd be able to say we don't need fully underwritten anymore.

MS. SUSAN ALLEN: This is the first time I've heard of reflexive questions on an application. You said that you ask one question, and, depending on that answer, you ask others. Could you give an example of that, of a reflexive question?

MR. TESTA: It would be a question where it would ask whether an applicant had any of these following conditions, and one of the conditions may be in the category of blood disorder.

If the applicant answers yes, it would ask another question and get down to hemophilia. If the answer is yes, it would ask whether the person has been hospitalized in the past 12 months. That would kind of tag the person. If the applicant answered that he hasn't been hospitalized for it in the past 12 months, and it may be 24 months, it would get passed to the next phase of underwriting. It doesn't mean it gets approved. There will be a score attached to that, but we would combine that with the other information that we picked up.

MS. ALLEN: It's the first time I've ever heard reflex-only in commenting about MIB and APS. What does reflex-only mean?

MS. DOLAN: Reflex means that they do not do that for all the applications coming through. They read the applications first, and then depending on the answers to the questions, they reflex back whether or not they even do the APS or the MIB