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## TELEINTERVIEWING—A GLOBAL SURVEY

Reassurer SCOR Global Life has just published the highlights of a worldwide survey of teleinterviewing it has carried out in partnership with SelectX Ltd and Hank George Inc. The survey consisted of over 70 questions and was issued to senior underwriting managers at insurers in North America, UK/Ireland, Continental Europe, South Africa, Australia/New Zealand, Asia, the Middle East and Latin America/Caribbean. Over 360 companies responded.

The survey reveals that teleinterviewing (TI) is catching on around the world: around three-quarters of companies in North America, the UK, Ireland, South Africa, Australia and New Zealand apply teleinterviewing in some form. Elsewhere, usage is highly variable, but in some markets reaches 30 percent of life insurers. In most markets over half the insurers who do not teleinterview are considering it or are actively in pilot, notably in most parts of Asia, in Spain and in Germany.

### Drivers for teleinterviews

It is interesting to look at the motivations for TI and how these have changed. For the early adopters in markets where TI has been firmly established for some time, the main reasons for its introduction were speeding up policy issue, reducing cost and reducing dependence on doctors' reports. But those coming later to the party have

seen the benefits as being reduction of agent involvement, reducing anti-selection and non-disclosure and improving customer service. And this second group are spot-on judgment-wise, because the biggest benefits of TI do stem from a new way of doing business that benefits customers and producers (faster and an altogether better experience) and carriers (more control, less non-disclosure).

Application-to-issue 'cycle' times were reduced according to almost half of companies, with a net reduction of between four and six days. But some companies reported an increase in cycle time, particularly at outset, maybe reflecting the problems of introducing an extra step or steps to the process.

While in the US and Canada teleinterviewing is predominantly routine, elsewhere the picture is mixed. For example, in the UK and Ireland, of the companies using teleinterviews, nearly half said they employed discretionary TIs (replacing a physician's report) only; only a third said they do routine TIs; and 12% employed a combination of the two.

### Producers

It seems that in many markets there are still barriers to be overcome in terms of convincing advisers of the benefits of teleinterviewing, and perhaps the greatest

barrier to overcome is perceived 'loss of control'. Interestingly, half of companies in North America, the UK, Europe, Australia and South Africa allow advisers to choose whether or not the application goes through a teleinterviewing process – something which risks a degree of antiselection.

Surprisingly, a significant minority of companies in North America, Australia and South Africa permit the sales adviser to be present during the teleinterview. It is difficult to see any justification for this, as it undermines one of the basic tenets of teleinterviewing, that of separating the intermediary from the evidence collection process.

It seems that outsource providers have been a powerful influence on the take-up of teleinterviewing. In markets where there is more than one teleinterview outsourcing service available, over half of companies outsource the function. Conversely, in markets with a single outsourcer provider or none at all, teleinterviewing drops off sharply. If a company does not yet do teleinterviewing, the predominant reason given was the lack of outsourcers and the high start-up costs of in-house development. Latin America stood out as a region where the take-up of teleinterviewing has been blocked by lack of outsourcing resource.

### Interviewer profile

One of the biggest differences between markets is the profile of the teleinterviewer. In the UK and Ireland, nurse interviewers predominate, largely driven by their use at certain outsourcers. Underwriters and call-centre staff (with some medical terminology training) account for the balance. By contrast, in North America, nurse

interviewers are largely unheard of owing to cost constraints, most being call-centre staff with some medical training. In Australia and Asia, the majority of interviewers are call-centre staff, underwriters or new business clerical staff.

[SEE GRAPHIC—TOP NEXT PAGE]

This raises the question of whether the profile of the interviewer makes a difference. Certainly nurse interviewers score well with consumers and that should translate to better levels of disclosure. But surely medical experience and training is not a prerequisite; anyone with the right interpersonal skills and the correct training in how to conduct an interview can be highly effective.

### Better disclosure

Does the theory of improved disclosure rates apply in practice? In all mature teleinterview markets more than three-quarters of companies responded positively. Companies also reported emphatically that the *quality* of disclosures has improved too, compared to conventional modes of history-taking; this was especially pronounced in the UK and Ireland in respect of disability income applications. Respondents with experience of TI felt that smoking habits were disclosed more truthfully – especially important where use of tobacco products is a determining factor for the basic premium rate.

[SEE GRAPHIC—BOTTOM NEXT PAGE]

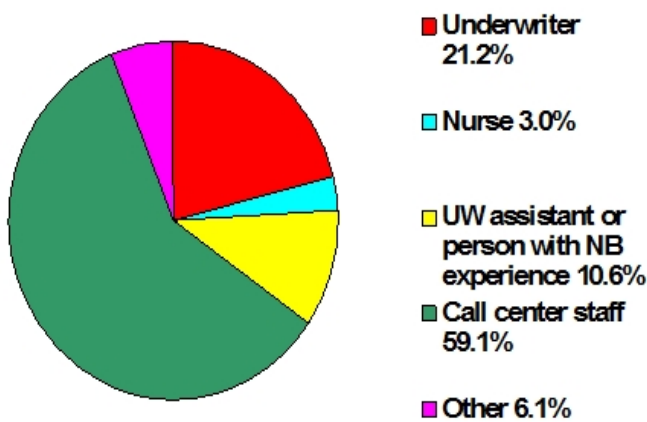
According to the survey, TI use is skewed towards the younger ages. This is somewhat puzzling given that the value of teleinterviewing is highest among older applicants – who naturally tend to have more 'interesting' health histories and therefore more to disclose. Do underwriting managers feel that because they are getting

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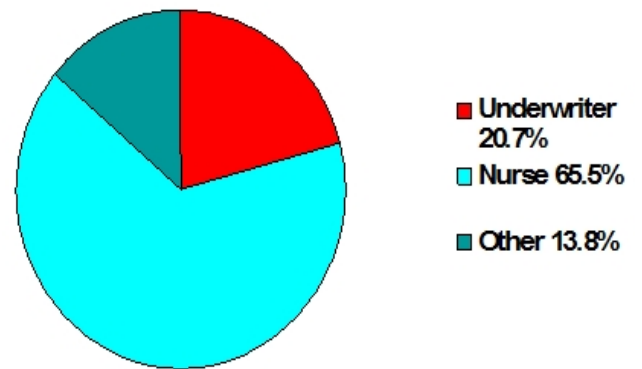
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# Interviewer profiles

## N America



## UK/Ireland



## Reduced non-disclosure?

### N America



### UK/Ireland



routine APSs on older lives an interview is redundant? This would be a real mistake. The value of the teleinterview rises with age – in line with the mortality and morbidity curves – and may be actually preferable to a physician report.

### The big question...

The big question, of course, is whether the promised benefits of improved mortality and morbidity experience are happening in practice. For most markets it is still too soon to estimate the impact. But almost no respondents to the survey believed that TI had had an adverse effect, and in fact responses suggest an overwhelmingly positive impact on experience, with:

- Increases in disclosure rates and the numbers of declared smokers
- Improvement in the overall quality of disclosures
- Increases in the proportion of rated cases
- For most companies, no increases in not-proceeded-with cases
- Less material non-disclosure and fewer costly claims disputes and claims admitted.

As a result, most reinsurers, at least in Europe, are now sufficiently confident that they are prepared to offer significant discounts to companies following best practice in terms of interview quality and process, enabling their client carriers to offer more competitive rates or increase their profit margins.

So teleinterviewing looks increasingly a mainstream way of gathering risk information around the world. This can only be a good thing for prudent risk management. When one examines the pitfalls and the inherent risks associated with the traditional producer-mediated app, TI is clearly a far superior process.

## CHRONIC PAIN

Chronic pain syndromes such as work-related upper limb disorder (repetitive strain injury), chronic fatigue syndrome (CFS), fibromyalgia and temporomandibular joint disorder (TMD) are becoming increasingly familiar. But in the world of chronic pain there are newer diagnoses, such as:

- Reflex neurovascular dystrophy
- Complex regional pain syndrome
- Reflex sympathetic dystrophy
- Causalgia
- Myofascial syndrome
- Sudeck's atrophy (or dystrophy)
- Algodystrophy
- Pain amplification syndrome, and
- Benign hypermobility joint syndrome.

A number of similarities run through the majority of these conditions and there is considerable overlap of symptoms. For example, in addition to chronic pain there may be depression, sleep disturbance or abdominal symptoms. In one study, irritable bowel syndrome (IBS, yet another diagnosis coined for a collection of non-specific symptoms) was seen in 92% of those with CFS, 77% of those with fibromyalgia and 64% with TMD. This compares with 10% to 15% in the general population.

Often there is no specific treatment; indeed medical treatment is usually of limited effectiveness, although some patients report that low doses of drugs such as amitriptyline can help, not only to reduce the pain but also to aid sleeping. In many there is an overlap with psychological problems; indeed, cognitive behavioral therapy is one of the most commonly used interventions. A graded exercise program, physiotherapy and occupational therapy can also be beneficial in preventing a decrease in aerobic fitness, which may prolong the period

of disability. Despite a multitude of normal investigations the pain associated with these disorders is very real. Often it starts after an injury and stress seems to play a role. Sometimes the affected area can turn red or blue suggesting that the nerve pathways are disrupted or there is decreased blood supply.

The diagnosis of chronic pain syndrome itself is usually by the exclusion of other causes of chronic pain. Indeed, some clinicians have moved away from the diagnosis of fibromyalgia as they find it 'unhelpful' because of the many Internet sites focusing on the seriousness of symptoms but with little or no information about treatment or prognosis. Physicians also need to avoid unnecessary and inappropriate investigations and referral, which often just increase the anxiety of the patient. It is important to avoid an endless quest for a non-existent diagnosis.

If the conditions listed above were not enough, consider two more. One is *hypermobility*, in which joints are able to stretch or bend further than normal, and which is often seen in the thumbs or wrists. It is recognized as a risk factor for many of these chronic pain disorders, as well as for panic disorder and mitral valve prolapse. Some of those with hypermobility have no other symptoms or medical conditions, but others have chronic pain and weakness thought to result from muscles having to work harder to compensate for weakness in the joint-supporting ligaments. There may also be a particular propensity to injury.

A common thread through a number of these disorders is changes in the way the brain deals with pain; either the pain becomes amplified through abnormal pathways in the nervous system, or the brain becomes less able to filter pain – which is why *pain amplification syndrome* is now a bona fide diagnosis and can be made even when a patient does not meet the diagnostic criteria for fibromyalgia or CFS. Emotional problems such as depression and feelings of helplessness often co-exist, aggravating the picture.

While these new diagnoses are largely trivial in the context of life cover, they are clearly highly significant for disability business. But managing these risks presents a real challenge. Prognostic information is sparse. Treatment regimens will come and go; currently they range from the conventional to the truly *avant garde*; if you look askance at acupuncture, consider stroking a paintbrush on the affected area or pouring on dry rice or popcorn. However, some appear to have encouraging results; non-invasive brain stimulation (repetitive transcranial magnetic stimulation [rTMS], and transcranial direct current stimulation [tDCS]) have been used to good effect in some patients with chronic pain, but further studies are needed.

Exclusion clauses demand particular attention if they are to be effective (especially given the phenomenon of 'diagnosis creep', the likelihood of which can increase if an insurance policy is involved...). For example, hypermobility is associated with IBS, and both of these are in turn closely linked with both chronic fatigue syndrome and fibromyalgia. So an apparently straightforward case of IBS may later develop into something rather more complicated – quite possibly rendering an IBS exclusion next to useless.

The chronic pain syndromes represent a facet of the trend towards the 'medicalisation' of non-specific symptoms and the loss of personal resilience towards life's challenges and adversities. But like it or not, they are here to stay, and we will all have to get to grips with what appears to be an uncomfortable truth: that just because there is no specific diagnostic test for one of these conditions, it does not mean that it doesn't exist.

#### Further reading:

1. Aaron LA, Burke MM, Buchwald D. Overlapping conditions among patients with chronic fatigue syndrome, fibromyalgia and temporomandibular disorder. *Arch Intern Med* 2000; 160: 221-7.

2. [www.rsds.org/4/youth/pdf/](http://www.rsds.org/4/youth/pdf/)

*AMP\_RNDparentHandout.pdf* (Accessed 16/5/2009)

3. Fregni F, Freedman S, Paschal-Leone A. Recent advances in the treatment of chronic pain with non-invasive brain stimulation techniques. *Lancet Neurol* 2007; 6: 188-91.

## UNDERWRITING MANUALS: STRATEGIC DILEMMAS PART 3

Previously in this series on underwriting manuals we have considered:

- Maintaining and resourcing a manual
- Issues of access, security and usage
- Training content, and
- A supporting evidence base.

In the final part of this trilogy we look at the use of calculators and consider possible future developments.

### Calculators

The use of calculators to produce a decision is growing in popularity. But does the use of a clever 'black box' reduce the need for the traditional skills of the experienced underwriter? Or is there a place for both art and science in the underwriting process?

A number of manuals now feature calculators, and for a number of reasons:

- To enable quicker and easier decision-making, for example when blood pressure readings need to be averaged
- To lead the underwriter through the decision-making process to ensure that no steps are omitted
- To assist on complex cases, for example where a number of cardiovascular risk factors interact



**If you read Underwriter e-ALERT, you should also read Hank's *JournalScan*, which focuses on the current medical literature, reporting on and analyzing studies of importance to mortality and morbidity underwriting. For a sample issue, contact Esther at [LedesmaE@aol.com](mailto:LedesmaE@aol.com) or visit [www.hankgeorgeinc.com](http://www.hankgeorgeinc.com).**

with each other, and where reaching a decision requires more than simply summing the ratings for each risk factor.

Calculators are rather a two-edged sword. They have the benefit of assuming responsibility for complex rating calculations, thus reducing the scope for error. But then there is the risk that the underwriter relies overly on the answer that the calculator produces and fails to see the overall picture presented – including those risk factors *not* covered by the software. After all, underwriters are paid to make judgments; it's what makes them worth their salaries.

However, in these days of reinsurers wanting their clients to follow their underwriting guidelines correctly, there appears to be a trend for manuals to push underwriters away from making judgments towards a more 'prescribed' approach. One could argue that the desire for adherence to rating guidelines is diluting some of the traditional skills of the underwriter. Clearly a balance is required, but defining where that balance lies, and how to create and maintain it, is for another discussion.

### So what of the future?

The world of insurance has seen enormous change in the last twenty years (or so one likes to think) and this pace of change is constantly accelerating, giving rise to a number of questions, such as:

- Experienced underwriters are increasingly fewer in number. So how does a company capture the knowledge of its experienced underwriters for the decision making process of the future? How does knowledge management fit with an underwriting manual?
- How does the manual fit with the new culture of talent management and continual professional development (CPD)? Is it a training tool in its own right or one piece of a larger jigsaw puzzle embracing on line learning, knowledge management, CPD and informal learning to deliver a 'just in time' approach to knowledge and learning?
- Do the new initiatives on the Web described as 'Web 2.0', blogs, wikis, informal networking and other collaborative ways of interaction have a place in the underwriting manual of the future?
- And finally what impact do new business process developments such as straight-through processing, rules engines, teleinterviewing have on the underwriting manual? With the advent of teleinterviews, are the risk classification systems of traditional manuals still valid?

With an increasing desire to differentiate and increasing levels of consolidation in the industry, will there be increasing numbers of direct writers deciding to produce their own manual? And what will the underwriting manual of the future look like? The answer is that it will either be quite different to how it is are now or even unrecognizable, having metamorphosed into a more integrated approach to providing underwriters a wider range of tools needed to enable more efficient and effective risk appraisal.

## PUBLISHER'S COMMENT— "PRESCRIBED UNDERWRITING"

*"... there appears to be a trend for manuals to push underwriters away from making judgments towards a more 'prescribed' approach."*

On U.S. television, IBM was recently running a commercial that essentially makes the claim that mathematics can solve nearly all the world's problems. In the aftermath of the September 2008 economic collapse on Wall Street, such claims are dubious at best.

Sophisticated mathematical modeling using complex algorithms played a critical role in the calculations for the securitization of credit risk for the sub-prime mortgage markets, credit default swaps and other derivatives. And we all know how clever they turned out to be.

Complex algorithms are inarguably a valuable tool when constructing an underwriting engine calculator. But the old "combination debit" that prehistoric underwriters used in the days of paper manuals lent a certain comfort to us Neanderthals. Our experience contributed as much to our instincts and intuition as did our formal underwriting education.

There will be no argument here that human reasoning is always superior to mathematics. Errors in judgment are part of what it means to be human. Underwriting engines have certainly delivered on the promise of reducing human error. But underwriting is not a pure science. Nor is it all that much an art. It is *all business*.

Formulas are marvelous tools for developing transactional efficiency. But life and living benefits insurance underwriting is not just a financial "transaction." It is fundamentally a due-diligence evaluation of a long-term contract offer. There's no adverse selection in the purchase of a refrigerator.

The "smell test" algorithm probably hasn't been developed yet. No doubt, though, some earnest actuary is studying both olfactory science and metaphysics in order to fashion a formula for lack of trust.

## DEPRESSION MORTALITY

"Levels of anxiety and depression as predictors of mortality: the HUNT study" (*The British Journal of Psychiatry* (2009) 195:118-125. doi: 10.1192/

bjp.bp.108.054866) concludes that "Case-level depression was associated with increased mortality (hazard ratio (HR) = 1.52, 95% CI 1.35–1.72) comparable with that of smoking (HR = 1.59, 95% CI 1.44–1.75), and which was only partly explained by somatic symptoms/conditions."

"Unlike smoking, we don't know how causal the association with depression is, but it does suggest that more attention should be paid to this link because the association persisted after adjusting for many other factors," lead researcher Dr. Robert Stewart, of Kings College London, said in a news release from the college.

Like the chronic pain syndromes (see article on page 4), chronic depression typically involves comorbid conditions—insomnia, GI disturbances, dietary indiscretion, substance abuse, etc. In isolation, chronic depression can be relieved, but is rarely "cured."

Cumulatively, depression and its comorbidities add up to a ticking bomb. By the time a successful treatment is found, the comorbidities may have left systemic damage. The cause of premature death may be cardiovascular, respiratory, liver disease, etc.

The researchers also found that those who were both depressed and anxious had a lower mortality than those not reporting anxiety symptoms. "It appears that we're talking about two risk groups here," Stewart said. "People with very high levels of anxiety symptoms may be naturally more vulnerable due to stress, for example through the effects stress has on cardiovascular outcomes. On the other hand, people who score very low on anxiety measures, i.e. those who deny any symptoms at all, may be people who also tend not to seek help for physical conditions or they may be people who tend to take risks. This would explain the higher mortality."

The bottom line for life underwriters is that chronic depression, as differentiated from situational depression, requires a more thorough risk analysis with attention paid to the comorbidities. Suicide is not necessarily the primary mortality risk in histories of chronic depression.



## FINANCIAL UNDERWRITING CLINIC

### DUE DILIGENCE IN 2009

Banks and other lenders are resisting loans to many businesses since the September 2008 financial crisis. But "entrepreneurs" are viewed as especially loathsome for credit risk. Most new business ventures must seek out private capital to fund start-up operations. Also, many private companies that are expanding despite the recession may consider an IPO when lenders shut their doors to them.

In this climate, careful and cautious due diligence has been resurrected as the smart strategy for investing in new or established companies. And consulting firms specializing in due diligence are beginning to thrive. One such firm, Astute Diligence ([www.astutediligence.com](http://www.astutediligence.com)), "performs due diligence and business analysis for organizations that are contemplating investments, strategic partnerships, mergers and acquisitions or that are looking to enhance organizational effectiveness in an existing business unit or portfolio company."

Among many useful pages at this website is a sample due diligence checklist which is much too lengthy to be included in this article. But as Astute Diligence writes, "Due diligence checklists provide a starting point for the due diligence effort. This document gathering effort is augmented with many other techniques, including management capability assessments, benchmarking of operational performance, interviewing customers and suppliers, and analysis of

business models and projections." Aside from "General Financial Information," the due diligence investigation re-searches:

- "Corporate Records"
- "Intellectual Property"
- "Material Agreements"
- "Personnel and Employee Benefits"
- "Rights, Permits and Other Regulatory Matters"
- "Litigation, Investigations and Other Disputes"

and much more.

Underwriters must also perform due diligence - the larger the death benefit, the greater the detail needed to make an informed risk decision. Negotiating for less information to speed an application along is foolish in today's economic climate.

Remember, your large amount death benefit carries no less risk than a venture capital investment. In fact, it may carry more risk because it is not securitized with the firm's assets like most venture capital agreements.

**For additional information about an inspection service whose investigators have skills in financial analysis and can talk intelligently with CPAs, corporate treasurers and other financial advisors, contact First Financial Underwriting Services Inc. Phone: (800) 570-3477 Fax: (800) 571-3477**

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