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## Modern risk appraisal: What should it be based on?

This article has been published in the January 2011 edition of Underwriter eAlert. To subscribe to receive free future editions of eAlert, please visit [www.underwriteralert.com](http://www.underwriteralert.com)

In one of those rare moments when the pressures of life seem temporarily to abate, a risk manager might be inclined to reflect with an open mind on whether his or her risk assessment process is really fit for the modern age. We often discuss here matters that affect the nature and availability of risk information and how the underwriting process might adapt, voluntarily or as a result of legislative force, to the changing world around us. Not that the world of life and disability insurance itself remains unchanged, of course: new products, new forms of medical evidence, new protocols for using them, new regulation, new technology... all have changed, sometimes substantially, how the underwriting process is conducted.

But has underwriting changed enough, particularly as regards the way we view and deal with medical and health risk factors?

Compared to 50 or more years ago when 'modern', scientific underwriting came of age and the familiar course of intermittent and incremental honing began, the world of medicine has changed no end. And in some ways the life insurance industry has responded to that pretty well by reflecting new diagnostics, new therapies and improved prognoses (and sometimes new medical conditions) in its underwriting guidelines. But a big change is that human physiology, the etiology of disease, risk factors and their influence and, of course, the impact of genetics are now so well understood. The drivers of mortality and morbidity are no longer a mystery to doctors (in many ways) and underwriters, as well as (and especially) to the general public.

In North America, the answer to that question about sufficient change by the industry may be 'yes' – although arguably there is always more to do: the environment in which insurers operate is never still, never constant. In few places do insurers screen applicants and grade risk with such care and attention to detail as in the US and Canada. Partially this has been driven by product development in the shape of preferred-life pricing (although arguably this was born out of concerns about an explosion of AIDS deaths, which prompted widespread blood testing, and which in turn created the opportunity to test for other things).

But even in North America screening is biased towards cardiovascular risk, ignoring – smoking and alcohol aside – cancer, the other major source of mortality. But this is probably fair enough: although understanding of cancer risk is growing fast, objective tests are rare and not cost-effective, and information from applicants generally unreliable.

Elsewhere in the world some very different risk screening protocols apply. Blood and other fluid testing are done on a far lesser scale, and in the United Kingdom, for example, the 'pile it high, sell it cheap' approach prevails. Medical evidence is an anathema to insurers (and to producers). Compared with North America, huge amounts are accepted on the basis of an app alone. The equivalent of an APS is obtained at relatively high face amounts, and to require a medical (usually a relatively cursory exam done by a nurse) an applicant must be either quite old, wealthy (large sum insured) or sick. Fluid testing is reserved for almost stratospheric face amounts, and then insurers tend to be looking for an ECG before they think about phlebotomy.

Actually, it all works quite well and claims experience is reasonable. But then the Brits don't have sophisticated risk stratification: smokers are penalized (and non-smokers not tested for cotinine!) but that's it. This is surely a crude way of screening risk given what is known about risk factors. Is dumping the great majority of applicants into two standard pools (smokers and non-smokers) good enough? In other markets medical evidence may be more common but risk pricing no less crude. In much of Europe smokers and non-smokers are treated equally.

The counter-argument is that folk are only applying for life insurance coverage, and it should be as simple and quick as possible. And that is what consumers (and producers) in the UK have come to expect. And why attempts to introduce more sophisticated stratification of risk have been resisted. But if there are major cross-subsidies between risk groups the principle of equity between policyholders is lost. If knowledge about risk exists, aren't insurers under some moral obligation to apply it in their screening and pricing?

Another product of the knowledge explosion (research which first informs medical professionals and then becomes widely available through the power of the media, especially the Internet) is that applicants are far better informed than they used to be – it's that demystification of medicine. So the potential for antiselection is much greater. Successful transaction of insurance depends on parity of knowledge between insurer and insured through the doctrine of 'utmost good faith'. Modern consumers may scorn such doctrines but leaving aside conscious abuse, surely motivations *for* buying and thought processes *when* buying are different now? Sure, policies largely still have to be sold, but even so, the playing field is a different one and new rules – unwritten ones devised by the applicant – apply. And others are increasingly taking the do-it-yourself route. These aren't folk who just happened to bump into a sales guy and now find themselves applying for a policy; they have on their own made a conscious decision to buy and are taking action.

So assessing and pricing risk is a walk along a fine line whilst juggling the power of professional knowledge, the power of consumer knowledge, equity between policyholders, practicality, cost and market place culture – while at the same time maintaining a healthy level of prudence and avoiding the worst of antiselection. Currently that line isn't a tightrope across Niagara Falls, but you never know when it'll move there. (By the way, right now European carriers are awaiting a court decision that may just mean that they can no longer differentiate between men and women for life and disability premiums or annuity payouts [*Judgment now received: use of gender for determining insurance premiums or benefits now banned in the EU from 21December 2012*].) Risk managers owe it to customers to do the best for them while at the same time running a sound business. Sometimes you have to stand back and think about that.

Ah, that rare moment has come to an end. Back to the pressures of life.

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20 January 2011 (updated 3 March 2011)