

Bridging the Underwriter and the Applicant

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Effective client communication may be one of the simplest ways to compete in today's marketplace. A traditional approach to communication is compared with a more direct and informative method to which the medical director is uniquely suited.

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CASE 1

A 57-year-old dentist applies for \$1,000,000 of 20-year term insurance. On his application, he denies having any medical history, and he is a nonsmoker. He has not seen a physician since 1989. His insurance examination and lab include the following data: height 5 ft 9 in, weight 175 lb, and blood pressures of 130/58 mm Hg and 128/60 mm Hg. His blood and urine laboratory data include a blood glucose level of 180 mg/dL (range, 70–125), fructosamine level of 3.9 mmol/L (1.2–2.1), a hemoglobin A_{1c} (HGB A_{1c}) of 8.1% (range, 3–6), a cholesterol level of 250 mg/dL (range, 175–260), a triglyceride level of 260 mg/dL (range, 10–190), an high-density lipoprotein (HDL) level of 30 mg/dL (range, 41–83), and a microalbumin level of 2 mg/dL (range, 0–3).

Because of laboratory evidence consistent with undiagnosed diabetes, the underwriting decision is to offer a highly substandard rate

as a stretch, rather than to decline. The reason for the substandard rate given to the agent is "abnormal blood work." The agent conveys this to the client and requests that the applicant send to the home office a release of information authorization that will allow the underwriter to mail the results of the blood and urine tests to the applicant's physician. The case is never placed, no authorization arrives, and the applicant is not heard from again.

CASE 2

A 39-year-old attorney applies for \$750,000 25-year term insurance. On the application, she admits to smoking 1.5 packs of cigarettes daily. She has no physician. Her examination shows the following data: height 5 ft 5 in, weight 135 lb, blood pressures of 160/108 mm Hg, 158/100 mm Hg, and 140/102 mm Hg. Her insurance blood and urine labora-

tory test data include a blood glucose level of 130 mg/dL, a fructosamine level of 1.9 mmol/L, a triglyceride level of 160 mm/dL, an HDL level of 68 mg/dL, a blood urea nitrogen (BUN) level of 29 mg/dL (range, 5–25), a creatinine level of 1.9 mg/dL (range, 0.5–1.5), and a microalbumin level of 15 mg/dL.

The underwriting decision is to offer a highly substandard rate. The explanation given to the agent is “abnormal blood work.” The agent conveys this to her client. Again, the case is never placed, no authorization arrives, and the applicant is not heard from again.

These two cases have several commonalities. Physicians followed neither applicant, the applicants perceived their health to be normal, and neither case is issued. Depending on the insurance company, both cases may be offered at a substandard rate or declined. But either way, the outcome is usually the same, the case is not issued.

DISCUSSION

Traditionally, communication of medical information is between the insurance company and the applicant’s physician. It is assumed that the physician will receive the medical information and call the patient to discuss the abnormal test results. It is also assumed that the applicant is not knowledgeable enough to handle medical information. Lastly, many feel that sending abnormal test results will frighten an applicant. Because most individuals perceive their health to be excellent, they respond negatively to hearing that the medical information derived from the insurance application process showed a problem.

The business-as-usual approach goes as follows. The underwriter makes a final assessment for the risk (1 day). Noticing that the laboratory results are abnormal enough to have clinical significance, the underwriter sends a copy to the physician. Before sending it, however, he or she must get permission from the applicant to do so (add 4–10 days

to the process). The results are sent to the physician’s office, where it is placed in the patient’s chart (add 2–4 days to process). Having gone through many hands by now, the applicant stands a very good chance of never being informed about the problem.

So why the chain-of-custody method? Often, the reason given is, “We’ve always done it this way.”

As a corporate entity, what are we trying to accomplish in our day-to-day activity? Obviously, getting the policy issued is high on the list, but other important considerations are also noteworthy. For ethical and practical reasons, our applicants should be informed of any abnormal laboratory findings, which indicate a life threatening medical problem. From an applicant’s perspective, the knowledge may result in needed medical intervention; from the company’s perspective, improved medical care may result in improved mortality among those applicants issued a policy. Could there be a method that is inexpensive and convenient, and that puts the applicant, the physician, and the sales person on the same page? Could this same process desensitize the applicant when the agent has to come back to him or her to sell a substandard rating because of a medical problem that is unknown to the applicant? Let’s revisit the above cases and consider a different approach in communication that may yield a better outcome.

CASE 1

The underwriting choice is to either offer a highly substandard rate or postpone the application. Assuming the case would be a “not taken,” the underwriter opts to postpone the case and send the test results directly to the applicant. The medical director, in her own handwriting, puts directly onto the laboratory test result sheet a signed note that reads “Dr PI, your insurance urine and blood work show several blood sugar-related test results that are abnormal. These include glucose, fructosamine, HGB A_{1C}, and microalbumin (protein in the urine). I suggest you share this

data with your physician.” As soon as the agent gets word that the case is postponed, he calls the home office to ask what the problem is. The underwriter tells the agent that the laboratory results are abnormal enough to warrant medical follow-up and that this information had been forwarded to his client. The proposed insured gives a copy of the test results to both the agent and the physician, whom he is to see a week later. Nine months later, the agent presents the underwriter with an updated attending physician statement (APS) documenting well-controlled diabetes for the previous 6 months. The policy is issued despite a modest rating.

CASE 2

Again, the underwriting choice is to either offer a highly substandard rate or postpone the application. As in case 1, the underwriter opts to postpone the case and send the test results directly to the applicant. Also as in case 1, the medical director writes a note on the laboratory test result sheet that is mailed directly to the proposed insured. It says, “Ms PI, your insurance blood work is normal; the results are noted above. Your blood pressures

are 160/108, 158/100, and 140/102. As these are elevated, I suggest you present this information to a physician.” As soon as the agent gets word that the case is postponed, he calls the home office to ask what the problem is. He is advised that the insurance examination’s results are abnormal enough to warrant medical follow-up and that this information is forwarded to his client. The client gives a copy of the test results to both the agent and the physician, whom he is to see the next week. Nine months later, the agent presents the underwriter with an updated APS documenting well-controlled hypertension for the previous 6 months. The APS also includes a normal history, physical, and (screening) treadmill. The policy is issued standard.

CONCLUSION

The chances of getting a life insurance policy issued to a proposed insured that has abnormal laboratory or examination findings are enhanced by direct communication with him or her. Because the proposed insured is directly informed, the field can become privy to medical information without the insurance company breaching confidentiality. Finally, this process may result in preservation of life.