Correspondence

We welcome letters to the Editor. Provided we have the space, all appropriate letters will be published.

Underwriting - A Science and an Art

To The Editor: Dr. Jack Harnes' interesting and provocative editorial "Life Underwriting" in the last issue of Insurance Medicine deserves comment. Although there is much truth in what he had to say, I consider it less than the whole truth because it does not adequately reflect, in my opinion, the scope of underwriting which is currently available to aid revision of the underwriting manual and intelligent underwriting of the problem case. Underwriting is a science of applied statistics as well as an art and I don't think the statistics and their application are quite as bad as he painted them for the following reasons.

Past intercompany mortality studies have contributed greatly to an evolving pool of mortality statistics on many impairments, despite their limitations of heterogeneity and the time lag involved in collecting and publishing the data. Contrary to Harry Ungerleider's pessimistic forecast of 22 years ago, another badly needed intercompany mortality study of impairment is in the making right now and promises to be even more comprehensive than the 1951 study. As in the past, mortality will be studied by age, duration of follow-up, known duration of history of the impairment and severity, when information is available. Age at onset is much less important for an insurance mortality study than age at application because "retrospective" exposure cannot be used in any follow-up investigation. Clinical status of a living policyholder at the end of follow-up would be impractical to obtain and its lack does not in any way vitiate the mortality results. I firmly believe we should not abolish intercompany mortality studies but improve them, especially with respect to coding procedures and validity checks. Companies should support doing them with greater frequency. The Center for Medico-Actuarial Studies of the MIB provides an excellent mechanism for financing and data-processing as already demonstrated in the new build and blood pressure study and the atrial fibrillation study, but I agree its full potential has not yet been realized.

Insurance companies should also support more individual company studies and special prospective studies such as the atrial fibrillation study. The latter was initially explored and proposed by ALIMDA's Mortality and Morbidity Committee and approved by the Liaison Committee with the Society of Actuaries which set up an ad hoc committee with Dave Breithaupt as chairman and both medical and actuarial members and it arranged for data processing by the MIB's Center for Medico-Actuarial Studies. If the Executive Council desires more research planning on the part of the Liaison Committee, it is certainly free to make this request.

The retrieval, processing, publication and application of mortality data from current and past medical articles should continue. It is true that such data have to be interpreted with skill and care in any attempt to apply them to underwriting and this is a real challenge to all medical directors. The panel which discussed Medical Risks at the 1976 ALIMDA meeting included specific suggestions along these lines. There should be more exploration and publication from medical directors on this subject which pre-supposes a good working knowledge of life table methodology and the principles of comparative mortality. At least the Mortality and Morbidity Committee is encouraging the potential for work along these lines by sponsoring its mortality seminars, the fifth one of which will be held in New York this November 6-8.

Contrary to the concern expressed in the editorial, I believe there is a sound basis to anticipate that Volume 2 of Medical Risks will have somewhat better mortality date than the first volume. The new Committee and its Project Director, Ed Lew, can capitalize on the experience gained in preparation of the 1976 volume, and it is my conviction that there is a steady increase in the number and quality of follow-up studies published in the medical literature from non-insurance sources. I hope that Volume 2 will include a chapter on "applications" (including underwriting), a chapter that had to be omitted from the first volume because, a version satisfactory to the editors could not be prepared in time to meet the final publication deadline.

One constructive action that might be taken by the life insurance industry is to establish liaison with and perhaps become involved in high-caliber ongoing epidemiological studies. An outstanding study in this classification is the Rochester Epidemiological Project, run by Dr. Leonard Kurland of the Mayo Clinic. The Liaison Committee has already responded to Dr. Kurland's invitation by appointing two of its members to explore with Dr. Kurland just how any joint effort might be set up. Because of the coding of virtually all medical care and follow-up information on some 60,000 residents of Olmsted County, this project is a statistical goldmine for the follow-up of the entire range of human diseases with accurate incidence data and lack of bias in range of severity in patients with a given disease. Furthermore, Ed Lew, as Project Director of the new Mortality Monograph Committee, has excellent contacts with epidemiologists in charge of many ongoing studies so that the latest results should be available for Volume 2.

Shopping of substandard cases is a tough problem and probably will always continue to be. However, I believe that some aspects of competition are healthy. They certainly help to keep us out of the clutches of antitrust suits and the advantage to the high-risk applicant is a very real one. There are honest cost considerations which enter into any company decision to rate cases lower than the mortality data justify. The shading of ratings for borderline hypertension is such a universal practice in company manuals that any attempt on the part of one company to increase the
ratings unilaterally (really, to impose a rating on borderline standard cases) could increase acquisition costs through stimulating an exodus of veteran, highly productive agents to other companies. Yes, there is some inequity in adding slightly to the insurance cost for normotensive policyholders, but even companies which offer preferred risk insurance have a very wide range of mortality for policyholders in their standard category or categories. When carried to extremes, competition and ultra-liberal underwriting certainly are objectionable to most of us who believe in moderation and as much accuracy as feasible in the practice of risk classification. However, it does help to keep underwriting from being a dull job!

Although I have touched on many of the points raised in Dr. Harnes' editorial, I will not attempt to cover all of them, as I would rather keep this letter from getting too long. However, I cannot agree with his statement that "in the last five volumes of ALIMDA's Transactions" (not Proceedings) "there are only two insurance company mortality studies". In the 1974-1978 programs, (the 1978 volume is still unpublished) I count eight articles that give insurance mortality data, single company or intercompany, four related articles (including disability claim loss ratios rather than mortality) and six articles giving mortality or survival data from clinical sources. Be fair to our past presidents and program chairmen, Jack! Art Brown's 1976 program was particularly filled with mortality reports.

It would be interesting to hear from our colleagues as to what they think of the adequacy of ALIMDA's present support of mortality studies and how we can obtain more and better studies in the future. Perhaps our viewpoints are really no different than those of the storied characters, one of whom described in detail a vessel as being half empty and the other as half full. We certainly agree that the vessel needs more filling and I hope Dr. Harnes will lend his considerable talents to this task in the decade ahead.

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Mortality and Morbidity Committee

Reminder
Enclosed with this issue of Insurance Medicine are NOTES ON ATLANTA, which include places and events of interest, restaurants, golf and tennis schedules, special events.

Book Review

Differential Diagnosis
The Interpretation of Clinical Evidence

To date I have read in depth the first two chapters: Aortic Insufficiency and Circulatory Failure, and the sixth Chapter on Hypertension.

The book is intended primarily for the internist. But it certainly should be of general concern to all physicians who are either seeing patients or reviewing case records, which would include the medical underwriter.

Many of us in the insurance business are doing some clinical work, either as an occupational physician to our Head Office employees, or some hospital clinical practice. For the difficult diagnostic problems this book is invaluable.

The book contains 16 chapters -
1. Aortic Insufficiency
2. Circulatory Failure
3. Pain in the Chest and Abdomen
4. Sudden Death
5. Failure of Urinary Excretion
6. Hypertension
7. Hematemesis and Melena
8. Diseases of the Liver (Hapatomegaly, Portal Hypertension, Ascites, and Jaundice)
9. Diarrhea and Malabsorption
10. Lymphadenopathy and Splenomegaly
11. Some Hematological Problems
12. Fever of Obscure Origin
13. Diseases involving the Lungs or Mediastinum
14. Infections of the Nervous System
15. Some Neurological Problems
16. Special Diagnostic problems (including the Diagnosis of Certain Rare Diseases)

Each chapter is followed by case presentations from clinical-pathological conferences. These illustrative cases are also indexed.

There is a separate index of 59 Tables. In my opinion, these tables alone are well worth the price of the book. A few of the more significant tables are -

Classification of Heart Failure
Pain in the Chest
Differential Diagnosis of the Acute Abdomen
Classification of Hypertension
Causes of G.I. Bleeding
Causes of Hepatomegaly
Causes of Jaundice
Causes of Diarrhea
Causes of Splenomegaly
Conditions which may be associated with Hemoptysis
Causes of Seizures
Diseases that may present with Multisystemic Manifestations

I have specifically selected this group from the list because frequently we are given case summaries by the attending physician, without a specific diagnosis.

One always walks on very shaky ground, as an underwriter, in attempting to make a diagnosis from a case summary in which the attending physician is unwilling to come up with a working diagnosis, let alone a fully substantiated final diagnosis.

It is my opinion that one should be wary of being a diagnostician in our Head or Home Office underwriting departments, when we have inadequate medical data.

If we have serious symptoms such as hemoptysis, or hematemesis in an applicant in the cancer-age range, no firm diagnosis, and no exhaustive diagnostic work-up, I think we should be hesitant to offer insurance at any rating.

I feel that Harvey's Differential Diagnosis is a useful tool in assisting all of us to be more astute physicians and medical underwriters. It is my belief that anyone who makes a study of this book will have an outstanding reference to assist them in sorting out a working diagnosis when one is presented with adequate information, but no firm diagnosis.

I have purchased each edition as they were published. The first edition was helpful in completing my postgraduate studies and examinations in Internal Medicine. The third edition maintains the excellence of the preceding editions and incorporates the newer diagnostic procedures.

John A. Kilgour, M.D.
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Of Interest

G. William Jones, M.D., Vice President and Medical Director of the Equitable Life Insurance Company of Iowa had elected early retirement on July 1, 1979.

Dr. Lawrence W. Porter will assume responsibility for the medical staff operations in the Company with the title of Medical Director.

Dr. Richard B. Singer recently retired as Second Vice President and Director of Medical Research at The New England Mutual Life Ins. Co., wishes to inform his friends of his move to Maine. Dr. & Mrs. Singer's new address is Box no. 109, RFD1, York, Maine 03909.