

Will Hiring a Board-Certified Specialist Improve Your Company's Unfavorable Underwriting Results?

John R. Iacovino, MD

Some underwriting departments believe hiring a board-certified specialist from a clinical background will improve their life underwriting, expectancy estimations, and profitability. This is not a panacea for solving adverse underwriting expectations. The need is a potential red flag indicating internal underwriting deficiencies. The specialist comes with their own limitations, the most prominent being the lack of any experience in insurance medicine and risk selection. You will be depending on the least experienced medical director to correct your problems. Likely, one or more internal underwriting practices could be the root cause of the unfavorable results.

Address of Correspondent: John R. Iacovino, MD, Life Insurance Consulting Services, LLC; Iacovinoconsult@aol.com

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Unsatisfactory underwriting results can emanate from 3 in-house deficiencies:

- Inadequate medical director training, auditing, and continuing education
- Lack of an up-to-date evidence-based impairment manual
- Actuarial deficiencies with inappropriate anticipated death or longevity projections

I recommend that, prior to the expense of employing a board-certified physician directly from clinical practice, each of these areas be carefully vetted. Tidy your house first!

THE MEDICAL DIRECTOR

Transition from clinical practice to medical underwriting and risk selection is learning and mastering an entirely new skill set. In clinical practice, precise prediction of life expectancy is not essential. You treat the patient to the best of your ability and await the outcome. When asked by a patient or family member, "how long do I (they) have to live?" you render an answer, usually by experience, which often can be biased by past exposure and rarely

based on evidence-based medical literature. Clinical practice is identifying single risks, insurance medicine is identifying where a single risk resides in a large group, all with the same or similar impairment.

Too often, I have heard inexperienced (and even experienced) medical directors state, "when I was in practice, I had a patient with this impairment die in X number of years," fully failing to grasp the law of large numbers. You can under- or overestimate the life expectancy (hopefully minimally) of an individual in a group, but the law of large numbers will blend the early and late deaths and yield the average life expectancy of an applicant in the cohort. For complicated cases, the medical director must be cognitive, one who has the training and ability to factor positive and negative aspects of the applicant's clinical status to yield the most accurate risk analysis.

A specialist directly from practice will likely come from one of two groups. One, office-based. These physicians see cases with the most favorable and intermediate prognosis. They can be biased, by experience, to underestimate the life expectancy of an individual. A physician from a hospital-based practice, especially one

that specializes in malignancies, will see those with the worst prognosis. Treatment failures from office-based practices and those with major complications are referred to their care. Their experience can be biased by poor long-term survivals and shorter life expectancies.

Entrants into insurance medicine from clinical practice have little, if any, knowledge of life insurance products. They are most familiar with property/casualty products where the risk is reevaluated yearly, and premiums are adjusted accordingly. When learning that every policy issued is a potential death claim, the strong natural tendency is to become conservative to avoid an early death claim appearing on your desk. That fear is unfounded. Accurately underwritten applicants die prematurely; they die beyond their projected life expectancy. But the law of large numbers balances the two, and if underwriting estimations and pricing are sound, the product will be profitable. This innate, new-hire conservatism leads to cookbook underwriting where the medical director follows the impairment manual to the letter and assumes little risk. This anomalous mindset leads to overrated, overpriced, and non-competitive business.

Lack of in-house medical director experience and/or lack of insurance-based training in risk analysis is a major and serious contributor to the problem. How intensive and through was the initial, formal training of the new medical director? Were they offered a few weeks of remote case experience? Who did this training? What is the ongoing follow up for proficiency and continuing medical education?

Auditing is essential. This is the responsibility of the most experienced member of the medical department and is critical to your underwriting success. Are you currently auditing medical directors, especially remote, new hires, regularly?

How often? What is the feedback and remedial training to correct deficiencies? My experience is full-time in-house medical directors are usually coordinated with the company underwriting rules and expectations through constant on-site observation, training, auditing, and feedback. Remote medical directors commonly have less to none of these.

THE MEDICAL IMPAIRMENT MANUAL

Is your manual evidence-based on the current medical literature? Manuals are living documents; however, constant updating can be difficult. Thus, supplemental and continuing medical education by the supervising medical director is mandatory via video conferencing, etc. For a poorly performing impairment, simply increasing the debits should be superseded by research and further training to improve the cognitive ability of the medical director to define risks more accurately for the specific impairment. It must be emphasized that the manual is only a guide.

THE ACTUARIAL PROBLEM

Are the projected, expected deaths in cohort studies appropriate for your reference population? Underwriting can be perfect, but if anticipated (expected) deaths are inappropriate, results can be skewed unfavorably. For life products, the mortality ratio represents the accuracy of underwriting an individual impairment or class of impairments. Ideally, the ratio should approximate 100%. Inadequate underwriting and/or estimation of individual life expectancy will affect the numerator; actuarial inaccuracy of expected deaths will affect the denominator.