



**ADVISORY**  
COUNCIL

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*A Berkshire Hathaway Company*



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A horizontal banner image showing several hands of different skin tones stacked together in a supportive gesture. Overlaid on the hands is a network of white dots connected by thin white lines, suggesting a digital or interconnected theme. The background of the banner is a solid dark blue.

# Seeing is BE-lieving: A Case Study of Behavioral Economics in Action



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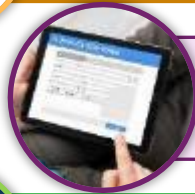
**SOMETIMES  
YOU NEED TO  
SEE FROM A  
DIFFERENT  
PERSPECTIVE**



## BE Concepts and Application Design



## Focus on Non-Disclosure



## The Impact of BE



## Case Study: Putting BE Into Action



## Questions



# BE Concepts and Application Design



# BE Concepts and Application Design

## Choice Overload



"The list of conditions shown is **too long** and **overwhelming**."



## Framing & Anchoring



"I'm not sure how to answer an open-ended question on the **number of alcoholic drinks I consume** per week."



## Nudging & Choice Architecture



"**Where are the instructions** for this section of the application?"





# Focus on Non-Disclosure



# Non-Disclosure: Accelerated Underwriting

Application Questions with  
the Worst Disclosure Rates

## Tobacco Use



## BMI



## Anxiety/Depression



“Less than half (44%)  
of companies report  
using a Behavioral  
Economics  
approach  
in developing  
AU application  
questions.”

Source: Gen Re, 2024 U.S. Individual Life Accelerated Underwriting Survey



# The Impact of BE

# Gen Re's Approach to BE Application Reviews





## Tobacco

Admission increased  
from 9.1% to 20.7%

**Disclosure more  
than doubled**



## Hazardous Sports

Admission increased  
from 4.0% to 8.1%

**Disclosure more  
than doubled**



## Nervous

Admission increased  
from 3.3% to 5.6%

**Disclosure  
increased by  
more than 60%**



## Digestive

Admission increased  
from 5.7% to 9.3%

**Disclosure  
increased by  
more than 60%**



# Case Study: Putting BE Into Action



- **Why BE?**

- First and foremost: The customer experience
  - Less taxing
  - Less follow-up
- Increased disclosure
- Reduced mortality/morbidity due to unintentional misrepresentation

- **Getting Started**

- Gen Re's BE Academy
  - Training the trainers
- IT Program
  - Large effort
  - Creating buy-in
  - 18 months

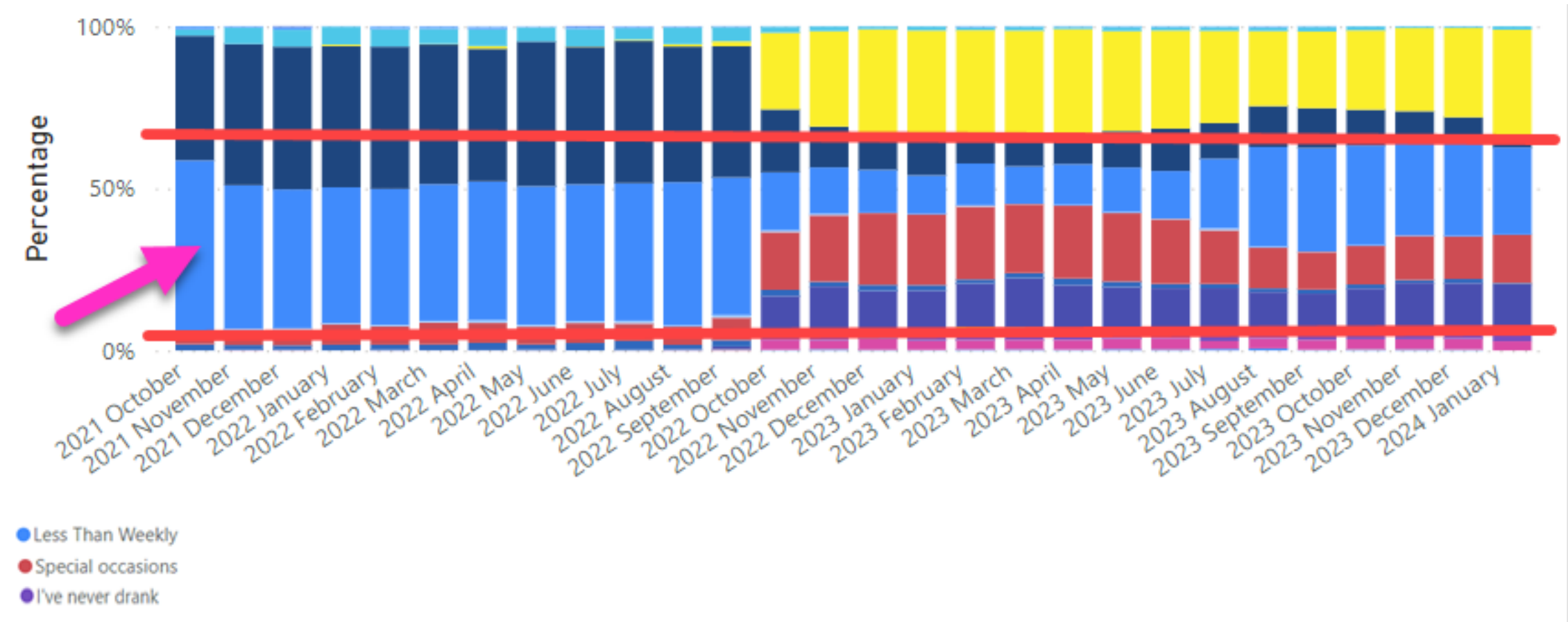




# Behavioral Economics Case Study – Results

Category	Jan21 -> Sept22	Oct22 -> Current	Percentage increase
Bone/Muscle	14.91%	19.04%	28%
Circulatory	17.15%	22.16%	29%
Clean Screen	17.21%	14.54%	-16%
Digestive	5.71%	9.25%	62%
Eyes/Ears	6.69%	9.00%	35%
Genitourinary	6.33%	8.86%	40%
Glandular	7.69%	8.73%	14%
Haz Sports	4.02%	8.09%	101%
Mental	11.65%	16.03%	38%
Nervous	3.32%	5.57%	68%
Respiratory	9.78%	10.70%	9%
Tobacco	9.10%	20.70%	127%
Tumor	6.28%	9.44%	50%

# Alcohol Responses



## Application Redesign

### Old - Tobacco

In the last ten years have you used any tobacco or nicotine products?..... ☐ Yes ☐ No  
(Indicate date last used and amount per day)

a. <input type="checkbox"/> cigarettes _____	d. <input type="checkbox"/> pipe _____
b. <input type="checkbox"/> cigars _____	e. <input type="checkbox"/> chewing tobacco/snuff _____
c. <input type="checkbox"/> nicotine patch/gum _____	f. <input type="checkbox"/> other _____

### New - Tobacco

When was the last time you used tobacco or nicotine products?

Name 1	Current	Within the past 12 months	1-2 years ago	2-3 years ago	3-5 years ago	Over 5 years ago	Never
Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chewing tobacco or snuff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine gum or patch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E-cigarette or vaping products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If Other is selected, explain: \_\_\_\_\_

## Application Redesign

### Old - Alcohol

In the last ten years have you consumed alcoholic beverages? ..... ☐ Yes ☐ No  
If yes, date last used? \_\_\_\_\_ Number of drinks per week: \_\_\_\_\_

### New - Alcohol

- How many alcoholic beverages do you drink per week?
- |   |  |
|---|--|
| <input type="checkbox"/> Less than Weekly | <input type="checkbox"/> 43 or more  |
| <input type="checkbox"/> 1-7              | <input type="checkbox"/> Temporarily not drinking (pregnancy, nursing, training) |
| <input type="checkbox"/> 8-14             | <input type="checkbox"/> Special Occasions                                       |
| <input type="checkbox"/> 15-21            | <input type="checkbox"/> No longer drinking                                      |
| <input type="checkbox"/> 22-28            | <input type="checkbox"/> I've never drank  |
| <input type="checkbox"/> 29-35            |  |
| <input type="checkbox"/> 36-42            |  |

## Application Redesign

### Old - CNS

seizure, paralysis, headaches, multiple sclerosis or any other disease or disorder of the brain or nervous system? .....

☐ Yes ☐ No

### New - CNS

#### 1. Brain/Cerebrovascular/Nervous System

##### Name 1

- |  |  |
|--|--|
| <input type="checkbox"/> Alzheimer's   | <input type="checkbox"/> Neuropathy            |
| <input type="checkbox"/> Cognitive Impairment  | <input type="checkbox"/> Paralysis             |
| <input type="checkbox"/> Dementia  | <input type="checkbox"/> Parkinson's Disease   |
| <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Headaches/Migraines   | <input type="checkbox"/> Seizure               |
| <input type="checkbox"/> Memory Loss   | <input type="checkbox"/> Tremor                |
| <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Vertigo               |
| <input type="checkbox"/> Narcolepsy  |  |
| <input type="checkbox"/> Other Neurological Condition not listed   |  |
| <input type="checkbox"/> I have not been diagnosed, treated, or consulted with a member of the medical profession for any Brain, Cerebrovascular, or Nervous System Condition. |  |

## Application Redesign

### Old - Medical Section

#### MEDICAL HISTORY (Provide details to yes answers, questions 18-20 below)

18. In the last ten years, have you been treated for or been diagnosed by a member of the medical profession as having:
- a. high blood pressure, heart attack, chest pain, heart murmur, irregular heart beat, stroke, or any other disease or disorder of the heart or blood vessels? ..... ☐ Yes ☐ No
  - b. cancer or a tumor, cyst or growth? ..... ☐ Yes ☐ No
  - c. asthma, bronchitis, emphysema, sleep apnea, tuberculosis or any other disease or disorder of the lungs or respiratory system? ..... ☐ Yes ☐ No
  - d. seizure, paralysis, headaches, multiple sclerosis or any other disease or disorder of the brain or nervous system? ..... ☐ Yes ☐ No
  - e. chronic fatigue, stress, depression, anxiety or any other emotional or psychological disorder? ..... ☐ Yes ☐ No
  - f. hepatitis, colitis, ulcer, cirrhosis, irritable bowel or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract? ..... ☐ Yes ☐ No
  - g. diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the glandular system? ..... ☐ Yes ☐ No
  - h. kidney stones, nephritis, any blood or protein in the urine, sexually transmitted disease, prostate disorder, breast disorder or any other disease or disorder of the urinary or reproductive system? ..... ☐ Yes ☐ No
  - i. back or neck pain, disc problems, spinal sprain or strain, sciatica, arthritis, carpal tunnel syndrome, or any other disease or disorder of the bones, joints, or muscles? ..... ☐ Yes ☐ No
  - j. any disease or disorder of the eyes, ears, nose, throat or skin? ..... ☐ Yes ☐ No
  - k. any disease or disorder of the immune system, except those related to the Human Immunodeficiency Virus (AIDS virus)? ..... ☐ Yes ☐ No
19. (DI Only) Are you currently pregnant or have you been diagnosed by a member of the medical profession as having complications of pregnancy in the last ten years? ..... ☐ Yes ☐ No
20. In the last ten years, have you been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immunodeficiency Syndrome (AIDS)? ..... ☐ Yes ☐ No

### New - Medical Section

#### 1. Brain/Cerebrovascular/Nervous System

Name 1

- |  |  |
|--|--|
| <input type="checkbox"/> Alzheimer's   | <input type="checkbox"/> Neuropathy            |
| <input type="checkbox"/> Cognitive Impairment  | <input type="checkbox"/> Paralysis             |
| <input type="checkbox"/> Dementia  | <input type="checkbox"/> Parkinson's Disease   |
| <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Headaches/Migraines   | <input type="checkbox"/> Seizure               |
| <input type="checkbox"/> Memory Loss   | <input type="checkbox"/> Tremor                |
| <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Vertigo               |
| <input type="checkbox"/> Narcolepsy  |  |
| <input type="checkbox"/> Other Neurological Condition not listed   |  |
| <input type="checkbox"/> I have not been diagnosed, treated, or consulted with a member of the medical profession for any Brain, Cerebrovascular, or Nervous System Condition. |  |

#### 2. Heart Disorder/Heart Disease/Peripheral Vascular

Name 1

- |  |  |
|--|--|
| <input type="checkbox"/> Aneurysm  | <input type="checkbox"/> Irregular Heartbeat             |
| <input type="checkbox"/> Atrial Fibrillation   | <input type="checkbox"/> Mitral Valve Prolapse           |
| <input type="checkbox"/> Chest Pain  | <input type="checkbox"/> Palpitations                    |
| <input type="checkbox"/> Coronary Artery Disease   | <input type="checkbox"/> Peripheral Vascular Disease     |
| <input type="checkbox"/> Deep Venous Thrombosis (DVT)  | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Transient Ischemic Attack (TIA) |
| <input type="checkbox"/> Heart Murmur  | <input type="checkbox"/> Use of a Defibrillator          |
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Use of a Pacemaker              |
| <input type="checkbox"/> High Cholesterol  | <input type="checkbox"/> Valve Disorder                  |
| <input type="checkbox"/> Other Heart, or Blood Vessel Condition not listed   |  |
| <input type="checkbox"/> I have not been diagnosed, treated, or consulted with a member of the medical profession for any Heart Disorder, Heart Disease, or Peripheral Vascular Disease or Disorder. |  |



## Choice Architecture: Examples

Section 1      Section 2      **Section 3**      Section 4

When was the last time you used tobacco or nicotine products?

Current    Within the past 12 months    **3-5 years ago**    6-12 months    Over 5 years ago    Never

Examples of other tobacco or nicotine products may include a hookah, nicotine mints, lozenges, sprays, etc.

Cigarettes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cigars	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you participated in any of the following sports in the past 5 years or intend to in the next 2 years?

Backcountry refers to participation in unmarked, unpatrolled, or off-trail areas.

☐ Automobile racing

☐ Backcountry\* skiing/snowboarding/snowmobiling

☐ Base jumping

☐ Bicycle racing

☐ Boxing

☐ Bungee jumping

☐ Drag racing

☐ Hang gliding or paragliding

☐ Helicopter skiing/snowboarding

☐ Hot air ballooning

☐ Motorcycle racing

☐ Mountain, rock, or ice climbing

☐ Mountain biking

☐ Parasailing

☐ Power boat racing

☐ Ski mountaineering

☐ Skin or scuba diving

☐ Skydiving

☐ Snowmobile racing

☐ I have not participated in any of these sports in the past 5 years nor intend to in the next 2 years.

# Questions?





# The Gen Re Behavioral Economics Academy

- **Module 1: Fundamentals of Behavioral Economics**

- The standard model, and systematic deviations from it

- **Module 2: Behavior in Insurance Markets**

- Applications of BE principles to insurance and customer engagement

- **Module 3: Applying Behavioral Economics**

- Designing and conducting experiments

- **Module 4: Analyzing Experimental Data**

- The statistical techniques required for processing experimental and other data



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# Thank you!



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