Report of the Ad Hoc Committee on Health Care Cost Containment and The Changing Role of the Insurance Medical Director

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Preface

Under the leadership of Paul Metzger, President of ALIMDA, the Executive Committee formally recognized (1) that the health insurance aspect of the life insurance industry constitutes a substantial and growing portion of the gross business of member companies; (2) that the cost of health insurance has escalated to a point that serious problems confront business and industry, government, the provider community, the consumer and the insurance industry itself, and; (3) the role of the insurance physician in this context may require examination, re-definition, and direction.

To this end, the ALIMDA Committee structure received instruction and impetus to attack the issues with alacrity and dispatch. One of the sub-committees appointed was an Ad Hoc Committee on Cost Containment, and the Changing Role of the Medical Director. The Committee was charged with the examination of these aspects of health insurance problems which currently confront ALIMDA members. An early report was requested.

Under the constraints of time and in the current expense control climate, it was literally impossible to convene meetings for the inter-personal discussion of the issues by the experienced Medical Directors who were nominated to serve on the Committee. It was promptly decided that establishment of a correspondence network was required, an agenda was designed, mailed to the participants, the responses returned and collated, the medical-economic literature and appended references reviewed and this preliminary report formulated for presentation to the Committee.

The covering letter of the agenda indicated that responses could be free in form and content and that replies would be confidential and not attributed. Several knowledgeable individuals, not originally nominated, and not members of ALIMDA, were asked to make contributions to this report. Their selections were made in an effort to avoid parochialism and provide, in a sense, controls and a dispassionate "second opinion".

It should be noted that all the physicians contacted responded promptly and with sincere, thoughtful, and, in some cases, very extensive and wide ranging, erudite essays. Some reports were succinct but nonetheless pertinent and contributory to the study.

The reports universally indicated not just an awareness of the problems which confront this segment of our industry but a deep, sincere, and intellectual concern for these issues. Many essays were buttressed with citations and/or reprints which, added to a small personal resource file, comprises the selected bibliography which is attached.

It is obvious that health care cost containment and the factors which generate costs are a major problem confronting the Insurance Medical Director. Not every aspect of the problem is recognized by each of the respondents; there is no universal course of action in this regard, but many of our members recognize the necessity for direction and support and the need for action.

In the design of any agenda of this type, it is necessary to translate the questions and issues which confront leadership into a plan for study.
Reference has been made to the constraints of time, the absence of personal dialogue, and the extent and complexity of the issues. As a result, this report cannot escape a degree of personal bias although efforts have been made to permit the voices of the members of the Committee to be heard. In addition, the occupational position of the Chairman is a unique one and it must be noted in evaluating objectivity. As a Medical Director concerned only with the administration of Medicare and Medicaid programs, the Chairman has a stronger authority and role in cost containment than his colleagues normally enjoy. Furnished with stronger, albeit imperfect laws, regulations, and policy language, not as exposed to punitive damages, and not as immediately subject to customer dissatisfaction and retribution in diminished sales as is his commercial counterpart, there is permitted to him a more partisan point of view. Personal attitudes, when apparent, must be viewed in this context. In addition, it is necessary to repeat formally that such views do not necessarily reflect the policy of either governmental program. It is noted, on the other hand, that much can be learned from the cost containment aspects of these programs and many techniques are transportable.

At this point, it is important to regard the obverse and recognize the contributions of each of those who responded to the hurried request for assistance. The daily mail was welcomed with great interest and enthusiasm for each response from a colleague was an original, usually delightful, and often challenging view of a complex problem. If there is any single universal conclusion from this study, it is that tremendous responsible, literate, and intellectual resource resides in the Insurance Medical Director. The Chairman extends his sincere appreciation to all those who contributed to this overview.

Introduction

To anyone familiar with the Source Book of Health Insurance Data, the history and significance of health insurance in the American economy is well understood. It does bear repeating that Health Care in all its aspects represents one of the largest of the major United States industries. It currently represents almost ten percent of the gross national product: 85% of 186 million Americans are protected by some form of private health insurance. Fourteen million citizens over the age of sixty-five, or 60% of this population, hold policies that provide supplemental coverage to Medicare.

Coverage is provided by hospital and medical service plans, by over a thousand private insurance companies through individual and group policies, by federal and state agencies, and by a variety of other prepaid plans, including the now established HMO mechanism.

Coverage varies from hospital expense insurance, surgical expense, and major medical expense in a variety of forms. Dental insurance is reputed to be the most rapidly growing form of health insurance. Disability insurance, although not included in this review, represents an established and widely accepted Health Insurance product.

The uninsured population is not clearly defined. Estimates vary but there is a clear indication that about 6% of the population, or 12.2 million people, are not insured at any particular moment in time.

These uninsured individuals, although a distinct minority, represents a minority of considerable importance with resulting strain on the economy.

Dr. Torrens has succinctly indicated the importance of health insurance in the economy when he stated in Lancet that, "health insurance is not just a neutral, value-free, administrative mechanism for paying bills — it affects every thing it touches." Indeed, after economic and defense policy issues, health insurance will more than likely be considered the single most important and continuing political issue over the last two or three decades.

Coincident with the pervasive concerns regarding the availability, access, and quality of medical care has been the current national consuming interest with the costs of health care. This concern is not only considered to be a rightful one but is acknowledged, at this point in time, to be intense. Although considered by Neuhauser to be not yet 'at the flash point', concerned students now return to the theme of cost when considering any aspects of health care in contrast to a marked lack of concern two decades ago, and the failure of the self-serving social theorist who desires to provide benefits while shifting costs.

"A comprehensive national health insurance system may, in fact, be an idea whose time has gone. Give the many interests that are now feasting upon the patchwork system that adds up to American medical care, it is altogether possible, in terms of political feasibility, that it is too late to encompass the pieces into any federally orchestrated system" (Greenberg, DS).

With this premise in mind, it remains not only possible, but necessary, and immediately so, for the competing, free enterprise system of private insurance to examine the costs of the present system, to evaluate mechanisms that promote efficiency in the operations of a potentially
viable and acknowledged necessary mechanism. To this end, the role of the Insurance Medical Director, as well as the insurance industry, is under close scrutiny.

Knowledgeable and concerned physicians in the insurance industry may quail before the criticism of Havighurst when he states that there exists an "assumption that health insurance is so destructive of cost consciousness that price competition among providers of health care is impossible. Insurers do not contemplate any increase in competitive developments that would seriously disrupt the status quo. However, in non-medical fields, "insurers recognize and protect against the moral hazard" — At the present moment, there appears to be an extreme tolerance and neglect of the presence of moral hazards in the administration of health insurance. We can accept Havighurst, deny him, do nothing, or recognize his insight and change course. The unique training and experience of the physician, knowledgeable in the insurance industry, may provide a "kindly light amidst the encircling gloom". In this context the problem of cost containment and the changing role of the Insurance Medical Director is opened to review.

Factors in Health Care Costs

The cost of "health care" may not be within the purview of the insurance industry. For health care and medical care are not the same. Medical care generally is provided after the occurrence of injury or illness. The costs incurred by such medical care are certain, the timing uncertain, and the risks shared by the insurance mechanism. Health care is an entirely different matter. It includes efforts to forestall disease, by developing resources, policies, institutions, agencies and attitudes concerned with housing, appropriate nutrition, substance (tobacco, alcohol, and drug) dependence, automotive and highway safety, measures directed toward abatement of homicide, suicide, and abuse of individuals. Abatement of safety risks in the home and work-place; the care and feeding of infants, children, and expectant mothers; processes; and the protection of the dependent, non-ill but elderly infirm citizen — these are health care but not necessarily medical care problems. The solution has too often been the medicalization of all social problems in the absence of other methods of reducing risks to health, safety, and general welfare.

Oppenheimer, writing in the New England Journal, clarifies the above distinction. "There is a difference between health care and medical care. The former is cheap, the latter expensive. The former treats groups; the latter treats individuals. The former teaches; the latter prescribes. The former prevents; the latter treats." These distinctions, unfortunately, are not understood by many. As Oppenheimer continues, "unless our leaders" (and social commentators, researchers, and theorists) "understand what doctors do well and what they do poorly, any national medical plan (or health insurance concept) will be an aggravating disappointment."

In reviewing the factors which result in health and medical care costs, we must recognize that fundamental to each factor, is a social imperative. These factors represent an expressed desire, made manifest, of the real concerns, fears, and needs of our citizens. "Physicians (and insurers) must stop apologizing for the cost of good medical care which is available to most citizens and one of the prizes of our civilization." (Silk, A.D.)

There are three major categories that generate costs of medical care. They are the patient, the provider, and the insurer. Not every category nor its components is given appropriate consideration when costs containment measures are considered.

The role of the consumer in generating costs has received only limited attention. A single Canadian and an Australian study objectively report the changing habit patterns of the patient after institution of universal health insurance. There are limited governmental studies of the costs of Medicaid recipient decisions to seek medical care in the emergency room setting. Bortz, Kern, and Hyde report on some changes in patient attitudes, albeit without any increase in longevity, resulting from the provision of "the finest possible" prepaid program provided for a group of older citizens.

The Governmental Health Care Programs Office of Prudential, in an unpublished study, reporting to HCFA identified the "top one hundred" patients in each of three states and defined the "demanding patient" and the "compliant, complacent physician." A medical care phenomena resulting in substantial costs to the program with limited benefit or quality of service. There are governmental and other statistical studies which indicate the changing patterns in institutional care. The elderly infirm widow whose mobile children are far distant has been displaced from the family home by real estate taxes and general inflation into the fast growing sub-industry of the long term nursing home. The mentally ill have been de-institutionalized only to become exploited by other housing and professional entrepreneurs. The incidence and costs of non-medical health care supplies and services provided by purveyors of diet supplements, weight control, and physical conditioning programs, over the counter medications, and the
services, quality, and costs of non-scientific or lesser professionals have been evaluated more carefully by stockbrokers than either the social or the medical scientist. It is an accepted fact that Americans demand first dollar coverage, unequal tax subsidization, and a most substantial benefit package. They insist upon and acquire first class institutional resources in their community. They demand and receive a level of sophisticated medical care without parallel anywhere else in the world.

The consumer is not without his advocate. Labor unions quickly identify the potential for the substitution of “in-kind” payment or medical insurance in place of salary. There is prompt recognition that first dollar coverage provided by the patient is payment in after-tax dollars, of increasing importance in view of inflation and bracket creeps. First dollar coverage and avoidance of co-insurance care are hard won and traditional benefits not easily given up. The proponents of all inclusive national health insurance from the ranks of labor may be an effort to remove this expensive benefit from the bargaining table.

The associations formed for the protection of the interests of the elderly, the retired, and certain occupational groups, seek to increase medical benefits without examination of the impact of their demands upon the general economy or the ultimate welfare of those they serve.

Medical charities and special interest groups devoted to specific diseases exert tremendous force in behalf of their constituencies who may actually be comprised of a limited number of individuals. The End-Stage Renal Disease Program of Medicare is the culmination of legislative and media activity of a few devoted, and powerful individuals. What began as a method to assist the few child victims of acute glomerulonephritis, a disease disappearing at the time, the effort was expanded to a billion dollar monster of uncertain efficacy, and never contemplated by many of its proponents. Veterans, the military services and their dependents, Merchant Seaman, the American Aborigines and welfare recipients demand and receive special interest, health or medical care legislation. It is difficult, at times, to assess the intent, the motivation, and the influences that result in actions by state and national legislators who mandate benefits, capitalize resources, and authorize programs of unproved value or validity always "in response to consumer demands". However, paraphrasing Ginsberg in his article on “The Competitive Solution", we would be in debt to all those who critically evaluate (these aspects) of the system forcing us to think more deeply about the existing shortcomings. An understanding of the medical consumer, the patient, and his perception of needs, his wants in contradistinction to his needs, and his expectations has not been achieved. It may be the most critical aspect of the medical care equation and cost containment. It is one which begs for scientific analysis.

Providers of medical care constitute a second major category which is responsible for medical care costs. It is now a widely accepted (and probably erroneous) conclusion that physicians by their decision making account for eighty-five percent of the expenditures for medical care. However, there are more providers of care than physicians. Their number is legion. Many go unrecognized. Although the physician is a most identifiable person in the equation, he is not further identified, nor his duties defined. Physicians may utilize primarily cognitive skills or they may be interventionists in regard to both diagnosis and treatment. The term "Physician" cannot be limited to the Doctor of Medicine or Osteopathy. The Dentist, Podiatrist, Chiropractor, Psychologist, the Nurse Practitioner and the Midwife, and the vast array of supporting therapy technicians, other semi-professionals, cultists and quacks are clamoring for recognition and reimbursement as they contribute, in growing numbers, to the Provider generated costs. The degree of such contributions has not been measured.

The drug industry; the manufacturer, distribution, sales and advertising of durable medical equipment and supplies; the agencies which provided research and the development of high technology; the hospital design and construction industry; the manufacturers and people involved in ambulance transportation and trucking; the banking and investment system; the nursing home, hospital and graduate and postgraduate medical education industries; the legal profession; and government regulatory agencies all contribute to the high cost of medical care. These costs are seldom mentioned let alone measured or understood. If the health care industry represents ten percent of the gross national product, it may involve some people one hundred percent, but it must be re-emphasized that it touches everyone at some point. Everyone contributes to costs!

Some aspects of society have a greater impact than others. Medical schools still limit their teaching of ethics and cost containment. The salaried house officer is not clear regarding his service or study model. The teaching hospital is "in search for more efficient ways to finance health care. All, including the government, must not lose sight of the fact that teaching hospitals reached their current position by responding to demands which Society placed upon them." In agreement with Ingelhart in this respect, there is an air of anxiety hanging over the teaching hospital for the status quo is no longer viable.
The "hospital" itself requires evaluation for it resists change and refuses to yield turf. Hill-Burton elevated and distributed hospital resources but there is refusal to accept the cost-effectiveness and improved quality of the transfer of patients to tertiary care systems in accordance with the Scandinavian prototype, resistance to consolidation, and unwarranted competition for pride and place.

A cost analysis of hospital care requires the "un-bundling" of resources and services since current accepted accounting practices obscure actual costs, inequities do occur, and costs are shifted. (Finkler, S.A.). Prospective rate setting, DRG reimbursement, and on-site auditing costs and services may only be quick fixes without the development of standardization of hospital accounting practices.

There is little doubt that innovative high technology may result in cost benefit and quality improvements for those patients who require such services. Only small efforts have been made by Government and others for pre-market certification of efficacy or determination of coverage. An outstanding exception being the Medical Necessity Program of the Blue Shield and its adoption by Medicare. However, inappropriate utilization of high technology combined with the collective expense of thousands of small tests and procedures, performed primarily within the walls of the office of the individual private practicing physicians, in the aggregate, have an enormous, incalculable fiscal impact. In addition, the shift toward invasive procedures and surgical intervention add to costs day by day. Additional "Provider" factors cited by Committee members and not to be ignored are the following:

Litigation and malpractice premiums. Defensive medicine resulting from litigation.
Over-organization and over-regulation by government resulting from perceived errors and omissions of the providers, individual and institutional.
The phenomenal increase in the number of medical students, the shift toward full-time teachers with a requirement for research and publication as a criteria for advancement. The subsequent trend toward super specialization and a preference for technical skills rather than cognitive skills by providers and patients.
The cost of medical education, the poor distribution, the inappropriate specialty population in excess of actual needs, and even the tendency for "flight from patient care."

For a comprehensive indictment of each and every element of the social organizations at fault in the costs of medical and health care, the indictment of Quentin Young, M.D., Chairman of the Department of Medicine of Cook County Hospital, in the Markle Scholars Symposium is formidable. Two outstanding and extensive contributions to the Committee report have been made by Robert Long, M.D., and William Kirby, M.D. Both sets of papers reveal a comprehensive understanding of the fundamental economic principles that form the basis of costs and social and professional practices plus numerous paths to be explored in the search for solutions.

And finally, to the classic model of the physician himself and his charges. Lister, commenting on the American scene from the more detached perspective of his London office, states that there is now a real "necessity for physicians to set the needs of patients above their own self interest."

A no more telling indictment of physician billing practices as one of the basic causes of escalation of medical care costs can be found than Roe writing in the New England Journal on "The URC Boondoggle". Other works listed in the bibliography comment on physician fees but Roe strikes between the eyes and epitomizes the strong adverse current among Committee members in regard to this aspect to cost escalation.

This section began with an effort to place physician responsibility in perspective but it ends with a need to place substantial responsibility on the shoulders of the individual physician, his teachers, his role models, his training, his professional leadership, his political leadership and his own personal attitude toward his fellow man.

The thesis of health insurance recognizes two social imperatives: protection from unpredictable expense and the congruence of utilization and need. The benefits of any policy should be constructed with need in mind. The Medicare emphasis on the requirement that reimbursement be based upon documented, reasonable and necessary treatment for a disease or injury best exemplifies this tenent. It is a cornerstone for policy construction. Insurance should not and need not be socially neutral. For too many years the industry may well have abdicated its role as a protagonist for cost effective, socially beneficial, quality medical care.

It is now accepted that full coverage can lead to increased utilization of services and continually rising costs and charges. Extensive coverage has broken the link between prices and charges. Ninety-four percent of hospital costs are paid by third parties and the treatment decisions by patients, physicians, institutions, and insurers are
not based on true costs. The current public attitude toward insurers who embark upon a new course of fiscal prudence is that denial of coverage is a broken promise; "there is no recognition of the absence of legal coverage: mechanisms for control are subject to circumvention, deception, and fraud". In the view of some, the prospects for the insurer are dismal: delay, political turmoil, high administrative and legal costs, loss of capital and earnings, and general dissatisfaction (Schwartz, W.B.).

The plight of the insurer is fateful. Absent acceptance of a common procedural terminology and a diagnostic nomenclature, communication and statistical analysis is impossible. Absent a broad fee data basis, costs are beyond control. Claims review has been, for the most part, avoided and professional direction lacking. Reliance upon PSRO's and Foundations for claims review places a reliance upon those who owe no loyalty to the insurance mechanisms. Audits of charges is a cursory review of the provision of services, literally non-existent, or not extended to include either a fiscal audit trail or an assessment of quality. The nature and extent of office services remain a mystery. Efforts for pre-admission testing, outpatient surgery, mandatory second opinion, prior authorization, and conformity to criteria for medical necessity have begun. However, co-ordination of benefits, firm exclusions, informed active resistance to mandated benefits, updating of policy provisions to exclude antiquated, inappropriate, unnecessary, research unproven, and unscientific services seems inadequate. Insurance must become a strong continuing force in health education at every possible level and in every possible way. Insurance companies can, and must provide sensible coverage and make the final decisions as to how much of a benefit they are going to pay.

It is remarkable that the Committee members, all of whom are both physicians and insurers, have recognized and reported all of the factors cited in this section of the report. The reports, in many instances, are as detailed, firm and extensive as above. In addition, they concur fully with Llyod Wescott, a farmer, philanthropist, and insurance company director, who provides the ultimate guide:

"It is obviously repeating a platitute, but an important one, to state that to provide true cost control without destroying the quality of care the following measures are essential: to prevent illness by every possible strategy; if that fails, to treat it early on an ambulatory basis; if unavoidable, to provide hospitalization that is expert and brief; and finally, to stress restorative and rehabilitative services."

The Changing Role of the Medical Director

Awareness, concern, introspection, some degree of alienation and the beginnings of an assumption of a new identity seem to characterize the responses of those who have made contributions to this review. Unanimity of opinion is not to be achieved among physicians. However, in some respects, there is a consensus and some remarkable changes in professional activities seems to have occurred.

There is a great awareness among Medical Directors of the multiple factors that have impelled medical care costs upwards. These observations have been noted in a preceding section. They comprise social, economic, and professional factors. There is an indication that the Medical Director considers that he may be more sensitive to the nature, extent and complexity of these factors than his corporate and professional leadership.

Concern appears to be manifest on two levels. There is a concern that dedication to the specialty of medical underwriting may have minimized the growing economic problem resulting from inattention to the "lesser" lines of commercial health insurance.

The second and even greater concern is for the integrity of the industry. A clear response such as, "we have lost some potentially lucrative cases because we are not strong in the area of cost containment" and "in some areas, companies with a major presence are encouraging the development of programs that analyze claims experience" indicate a real concern among the Medical Directors. Kirby, in his review, has determined the presence of a pervasive concern among both Occupational Medicine and Insurance Directors in regard to the integrity and the viability of the present system without serious attention to cost containment with leadership from professionals.

There is a considerable element of self-examination or identity identification evident in the responses. One respondent states, "I feel strongly that Medical Directors are not going to get out of their restrained area in the foreseeable future and that there is not going to be any remarkable change in the attitude of management towards medical directors insofar as influencing or participating directly in company originated committees or panels." Another states, "The role of the Medical Director appears to be that of providing background and advice to force the issue. At the present time it would appear to be unwise to endeavor to change." And a third, "I have not been involved in the broad planning by the company for medical cost containment."

On the other hand, consider: "The Corporate Medical Director (insurance or industry) is essen-
tially the senior corporate officer for cost containment guidance in addition to all other duties.” And “the need for leadership in strong, well qualified professional claims review systems must be emphasized.” And finally: “currently, in our company, the Medical Director plays an active part in the formulation of policy language and design, expansion or retraction of benefits, innovative or obsolete procedures.”

It appears that there is no present firm definition, or wide acceptance, of the function of the Insurance Medical Director in medical care cost containment. However, it is apparent that everyone is beginning to ask questions of himself, that attitudes are changing, and that, in some instances, firm steps have been taken.

The questioning attitude is confirmed by the taint of frustration and alienation that creeps into and colors responses. On the survey, there are repeated references to sales and marketing efforts conducted without utilization of professional resources. The emphasis is on production and sales. “Our companies must share the blame for the current situation because of complicated, ambiguous and fraud-inviting wording of specific policies”. “We shall not contain costs as long as we remain a competitive industry and each company falls all over itself to give more goodies than its competition.” “The product is not being designed and marketed, but rather the effort is to sell whatever the customer will furnish”.

The frank expression of this vein of frustration is notable, seems pervasive, and appears to be strongest among our younger colleagues. And the sense of alienation of the Medical Director extends beyond his company to his organizations. The reply of a most senior respondent is illustrative. He writes, “we are desperate for leadership. I have a very healthy skepticism, tempered by limited participation and experience, of the ability, competence — or even the interest — of HIAA to undertake a cataclysmic reform of American medical care which could only have as its primary objective that of controlling health care costs to a level of affordability.” Paraphrased, he continues: “Eventually, ALIMDA will need to broaden its scope and attract, alert, educate, and coordinate the efforts of members in all fields and health insurance in regard to cost containment.”

In summary, our respondent ALIMDA members recognize the escalation of health care costs. They are exquisitely aware of the multiple factors at work and their complex inter-relationships. They are knowledgeable beyond many in their own companies.

Our respondents are not only studious and aware of the issues but are reflective of their own role in the schema of the problem and their self-examination is leading to a re-definition of the needs of our industry, the companies with which they are associated and their own identity. Frustrated by a somewhat cavalier attitude of kindly neglect and lack of involvement, they continue to be independent, earnest in their concern, and frank and forthright in their expression of it. They seek a solution, and desire that their own professional organizations be responsive.

What are the actual future prospects for the Insurance Medical Director in cost containment? It appears that the future has already arrived and it will be driven at an accelerating pace by the engine of pure economics.

One respondent writes:

“Our company shares the industry’s concern over rising health costs and has established, an elaborate system of claims control culminating in the Claims Consultation Division headed by a Medical Director and staffed by physicians, dentists, and administrative personnel.

“Claims are reviewed for appropriateness and quality of care as well as for costs after coverage, deductibles, and coordination of benefits have been checked by lay personnel.

“A detailed system of hospital audit was designed to monitor over-utilization and over-charges and extensive use of independent medical examiners is facilitated.

“The Medical Director plays an active part in the formulation of policy language and policy design and advises on benefits. He participates in claims reviews at renewal time and assists policyholder’s “medical staff in the establishment of absentee and hazard control programs, accident prevention and medical surveillance.”

In reviewing this particular response and quoting only a portion of it, it was considered that editorial emphasis should be placed on key words and phrases above. However, it is recommended that it simply be re-read for it appears to be a whole new charter for the Insurance Medical Director and an example of a fully implemented program of cost containment with maximum utilization of professional guidance and leadership.

In personal communication with Committee members, it has been resolved that one corollary in support of the above is required. Changes in the direction of career pathways occur in Medicine as in other endeavors and such changes are now more readily acceptable in our Society. It may be necessary to open our doors for the employment of clinically experienced physicians who desire to alter the course of their
life for suitable reasons. Carrier advancement and comparable reimbursement must not be precluded by such mid-life career changes for a benefit accrues to all the parties: the patients, the insurors, and the new clinical Medical Director.

Further, it appears that ALIMDA has recognized that it must expand its mission and consider health care issues within its purview.

It appears that justifiable conclusions may be made. There is a potential for change in the Insurance Medical Director; change is already occurring, and ALIMDA, its members, and related organizations should encourage, lead, and participate in the changes.

A Prediction

No one expects the government to be rational. Everyone knows what sort of plan will emerge over the next decade. It will pay all medical bills, will be grossly expensive, and will contain none of the educational or coercive measures of a "health" program. However, that is what it will be called. All the advocates will stress how much health will result from it.

They will be wrong. Once this becomes obvious, doctors will be blamed. Most will deserve it — not because they failed as physicians, but because they have promised what they cannot deliver.

Oppenheimer

Summary and Conclusions

This Committee report reflects an effort on the part of the leadership of ALIMDA to recognize the social and economic significance of the continuing escalation in medical care costs and to examine the position of the organization and its members in this regard. Under difficult time restraints, the Committee has formulated by correspondence a kind of preliminary report. The replies of Committee respondents indicate an acute awareness of the complexity of the issue and a general concern about the influence of the commercial health insurance industry on the etiology and the resolution of this issue. There is a deep and specific concern about the duties, responsibilities, and the identity of the Insurance Medical Director. The latter has contributed to the development of the speciality of medical life underwriting to a fine art and a respected science. However, the increasing involvement of the industry in health insurance seems to have occurred without the same degree of professional involvement of these same physicians and their specialty societies. It is apparent from the replies of the respondents that the Insurance Medical Director is extremely knowledgeable of the widely diverse factors that generate costs and particularly sensitive and informed of those factors that constitute direct personal care. Physicians know medical practice. This fact, overlooked, perhaps, is the fundamental basis for the Committee conclusions. The consensus seems to be that first, there is a need for professional medical input into the entire catena of health insurance from policy design through sales and marketing to claims payment.

Second, it appears that the current situation presents opportunities for career development and satisfaction. Third, it appears that generation of an awareness of the potential contribution of this professional resource is required. And fourth, there is an opportunity for ALIMDA to provide direction, education, and support.

Finally, it appears that this review follows the march of events. It is apparent that, in a number of instances, fully developed cost containment mechanisms have been designed and implemented with totally involved professional medical participation. These advances should be further reported, evaluated, and encouraged for the ultimate benefit of the patient, the physicians who serve them, our companies and our industry.

Two small "foot-notes" concerning specific recommendations must be reported. First, it is apparent that adoption of a common procedural terminology format must receive strong, active and continuing support from ALIMDA. A common language is the cornerstone of a science.

Second, in almost every response, there occurred a comment upon the economic destruction wrought by the UCR concept. This is accompanied by a recommendation of a return to a schedule of benefits.
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