The 1990s Medical Director and Health Insurance

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Summary

To avoid the worst effects of the looming health care crisis in America while preserving the best attributes of a free enterprise system, a fundamental overhaul in the way that health care is financed and delivered must occur in the 1990s. By virtue of their specialized training and pivotal role in the insurance industry where clinical, financial and management decision making must merge, health insurance medical directors are ideally positioned to shape the new order.

Insurance medical directors need only extend (as opposed to redirect) their expertise to include the disciplines of technology assessment, clinical decision analysis and outcome management to emerge as the logical leaders of this fundamental change in the health care delivery system. They are at the right place at the right time with the right stuff. Insurance Company CEOs would be advised to capitalize immediately on this unprecedented (but fleeting) opportunity to put these valuable physician executives to work.

I. BACKGROUND—THE LOOMING HEALTH CARE CRISIS

A. Health Care Cost Concerns Intensify

1. Public Sector Concerns

In 1988, health care costs consumed over $550 billion, representing more than 11% of the U.S. GNP. Even more alarming, at the current rate of cost increase, this dollar amount is expected to double by 1995 and quadruple by 2001 the first year of the Third Millennium. By 2011, Bush Administration officials have estimated, based on current increases and projected graying of the population, that the Medicare Program will exceed in costs that of Social Security and Defense combined. By that year, when the first “baby boomers” turn 65, the Medicare Program (if it has not already gone bankrupt) is projected to be running $150 - $250 billion annual deficits.

2. Private Sector Concerns

With increasing worldwide pressure on the U.S. Government to reduce and eventually eliminate its costly federal budget deficit, health care providers will increasingly shift costs to private sector purchasers (particularly corporations and indemnity plans) to compensate for increasingly more restrictive public sector reimbursement. This process resulted in an 18.6% increase in the cost of employee benefit plans in 1988, according to the A. Foster Higgins & Co. Annual Health Benefit Survey.\(^3\)

“The severity of this year’s (1988’s) increase took many by surprise, including, it seems, the insurance industry. Employees with insured plans experienced an average increase of only 13.7% in 1988. Self-funded plans, on the other hand, averaged a 24.8% increase in the same period. Clearly, the projected trend for 1988, as reflected in the rate of increase for insured plans, was far exceeded by the actual experience of self-funded employers. It is likely that those fully insured or experience-rated plans will find their 1989 premiums reflecting the deficit caused by the understated 1988 trend.”\(^3\) “Heralded as a revolution in health care delivery in 1973, HMOs promised that they would play a major role in controlling health care costs. Today, however, most employers report that their HMO premiums are as high or higher than their indemnity plan premiums; further, many believe that HMOs drive up their indemnity plan costs through adverse selection.”\(^3\)

“With an eye more to building market share than to effecting cost savings, traditional health care plan vendors have begun developing and selling PPOs with extensive lists of providers. These PPOs are attractive to employees (and thus to employers worried about acceptance) but generally less cost-effective: if every doctor and hospital in town is ‘preferred,’ how can the concept of volume discounts work?”\(^3\)

American companies are being increasingly pressured to improve the value (i.e., quality and price) of their own products and services which has been severely
undermined by their inability to control health plan costs. In addition, American employers are now facing the double whammy of compliance with Section 89 of the Tax Reform Act of 1986 (requiring them to offer comparable benefits to employees at all compensation levels) and the recent Financial Accounting Standards Board (FASB) regulation which will require all companies to reflect in their balance sheets the cost of prefunding current and future retired employee health benefits. Compliance with this latter regulation alone could decrease the median Fortune 500 firm’s profits by one-third or more.\(^4\) Add to all of this the increasing clamor in the federal and state legislatures throughout America for business to be the primary subsidizers of some universal health insurance plan which might pass in the 1990s.

All this is occurring to American business at a time when it must maintain or even enhance its health benefit plans to be able to attract and retain technologically sophisticated employees. This will be required to permit American business to compete with the financially well-heeled and highly educated Pacific Rim countries (Japan, Korea, Taiwan, Singapore), a neocapitalist People’s Republic of China (which will reincorporate the highly successful capitalistic Hong Kong in 1997), and an economically integrated Western Europe in 1992. This soon to be the “United States of Europe” in conjunction with China, is already establishing significant trade agreements with the resource-abundant, but technology-deficient neocapitalistic Soviet Union. It is clear that American business, as well as the government and its regulatory agencies, must act aggressively in the 1990s to contain health care costs at the same time that the clamor for increased quality and access for the 80 million uninsured and underinsured is increasing.

B. Health Care Quality and Access Concerns—Is There a Dilemma

If the 1980s could be characterized as the “Age of Health Care Cost Containment” (although, as discussed, little containment actually occurred), the 1990s may surely be characterized as the “Age of Health Care Quality and Access.” Containing health care costs while maintaining, or even improving, quality and access has long been considered to be a dilemma. But the systematic development of, and ongoing compliance with, medical standards for the structure, process and outcome of health care delivery will save sufficient dollars to permit universal access to care without the need to straddle either corporations or the people of this country with unprecedented increases in new costs and assessments. How insurance medical directors may play an important contributing role toward making this vision a reality will be introduced later in this article.

II. THE GROWING DEMAND FOR DEMONSTRABLE VALUE IN HEALTH CARE DELIVERY

A. Current Initiatives

1. Public Sector

The major public sector initiative to improve the value (i.e., clinical outcomes and cost-effectiveness) of health care delivery is HCFA’s Medical Effectiveness Initiative.\(^2\) Started during the Reagan Administration, this initiative is expected to receive a major boost through substantially increased funding for research in medical technology assessment and clinical outcomes during the Bush Administration. In essence, the goal of HCFA’s Medical Effectiveness Initiative is to identify and to communicate which, among diverse alternative diagnostic and therapeutic interventions, link in the most cost effective manner various clinical conditions with “acceptable” clinical outcomes.

The natural outgrowth of this initiative is expected to be the development of clinical practice guidelines for a broad spectrum of clinical conditions. Computers will be employed to establish these linkages in the large Medicare Uniform Claims Database. It is expected that any clinical practice guidelines arising from these linkages will be developed in cooperation with such groups as the U.S. Public Health Service, the NIH Consensus Development Group, the Office of Technology Assessment, the Institute of Medicine of the National Academy of Sciences and the AMA/Rand Corporation joint venture to develop clinical practice parameters.

Another major public sector initiative currently making its case to the U.S. Congress is the National Leadership Commission in Health Care (NLCHC) honorarily co-chaired by former Presidents Nixon, Ford and Carter. The NLCHC constitutes a blue ribbon panel of leaders drawn from all types of health care providers and purchasers (physicians, hospital executives, corporations, labor unions, insurance companies, consumers, the government, academic and research institutes). A central component of its plan to improve access to care while decreasing costs is its National Quality Improvement Initiative.\(^6\) According to the President of the NLCHC and former V.P. for Health Affairs of Sears, Henry Simmons, M.D., MPH, “... systematic continuous compliance with scientifically determined standards of care constitutes the major mechanism for controlling costs, and, improving access to and the quality of health care delivery in the 1990s.”\(^2\)

2. Private Sector Initiatives

Clearly, the public sector, evidenced by its two major initiatives above, is slowly but surely coming to the same conclusion that private sector visionaries did
III. INSURANCE MEDICAL DIRECTORS AS MEDICAL CARE VALUE PURCHASING AND ENHANCEMENT SPECIALISTS IN THE 1990s

A. Traditional Roles of Insurance Medical Directors

"Insurance medicine is a broad subject. Its scientific base is the study of mortality and morbidity. Its practice requires experience in clinical medicine. Its environment is the world of business. Its responsibilities are to the individual who applies for insurance, the company which employs its services, the industry as a whole and society at large."8

Insurance medical directors have fulfilled many different roles in the past. The list includes (but is not limited to) assessing the medical risks of applicants for insurance, determining the causes of mortality and morbidity, providing the medical defense against policyholder claims and designing preventive medicine plans to manage the health risks of subscriber populations. More recently, with insurer’s movement into health care provision through managed care systems, many insurance medical directors have assumed roles in managing the delivery and purchasing of health care services. Some medical directors have been retained by property and casualty insurers to assist in the review and defense of medical liability claims, as well as in the underwriting of those policies and the design of programs to manage liability risks.

B. Emerging Challenges

As health care becomes a trillion dollar industry in the early 1990s, its clinical, financial and managerial aspects will rapidly merge. The most important challenge throughout the decade and into the next century will be: how can the quality of and access to health care be maintained in an era of increasingly restricted resources?

Since there is no other environment (inside or outside of the “business world”) where clinical, financial and managerial talent must meet more than in insurance, medical directors with expertise in these spheres should be logical leaders in solving the problems of the 1990s healthcare industry.

C. The Need for Fundamental Change

One of the major reasons behind the looming health care crisis concerns the manner in which “insurance” has become less of a mechanism to protect against catastrophic loss, and more of a financial repository for reimbursement of a broadening scope of comprehensive health care services. Insurers, in general, and insurance medical directors, in particular, have become reactive gatekeepers to protect this repository.

But, preadmission certification, concurrent review, second opinion surgery and other programs intended to protect the financial repository from “inappropriate depletion” represent bandaids on an insurance and health care financing system which is hemorrhaging internally at the same time that it is being asked to donate more blood. In the 1990s insurance medical directors must become proactive designers of systems to help determine prospectively what types of health care providers and services should be included in partnerships with insurers.

What type of therapy is required for our current ail- ing insurance and health care financing system to recover in the 1990s and beyond? Quite simply, what is required is a fundamental change in the way health
care is purchased and delivered. The remainder of this article will focus on the nature of this fundamen-
tal change, and how insurance medical directors may
prepare themselves to be the logical "change agents."

D. Insurance Medical Directors as Change Agents

In the past, to a great extent, insurance medical di-
rectors have been cast in a reactionary role: reacting
to claims, reacting to changes in underwriting pol-
cies, even reacting to industry and societal trends.
However, the insurance medical director of the 1990s
has (or at least should acquire) the fundamental skills
necessary to help shape the new health care financ-
ing and delivery system which must begin to emerge
to prevent the worst consequences of the looming
crisis discussed at the beginning of this article.

It was stated that insurance medical directors have
developed expertise and experience in the study of
mortality and morbidity.6 But, this expertise is that
of clinical epidemiology. A logical progression for
insurance medical directors' education and applica-
tion is in the medically related areas of technology
assessment, clinical decision analysis and outcome
management. These latter areas represent the
cauldron in which the important mixing of clinical,
financial and managerial disciplines in the health care
industry is now occurring. With but an extension (as
opposed to a redirection) of their already developed
expertise, insurance medical directors will be well-
positioned to help effect the fundamental change
needed for a system in which these three vital
disciplines heretofore have existed almost in-
dependently of each other. In the 1990s, these
disciplines must become continuously interdepen-
dent and synergistic. Some specific areas in which
insurance medical directors can and should be leading
health care industry change agents in the 1990s in-
clude (but are not limited to) the following:

- As designers, implementors and overseers of auto-
mated medical care evaluation systems to be utilized
in assessing and comparing participating providers' quality and cost-effectiveness (as measured by the
severity-of-illness adjusted clinical outcomes of their patients and resources consumed relative to that
expected in achieving those outcomes);
- As developers, as assessors of the efficiency, effectiveness and appropriateness of different medical technologies in the diagnostic and therapeutic management of a broad spectrum of clinical conditions applying sound principles of clinical outcome, relative risk and decision analysis;
- As developers of clinical practice guidelines through the effective use of medical care evaluation systems and sound principles of technology assessment, clinical outcome management and decision analysis;
- As developers of evaluation system-facilitated, "needs-based," educational interventions for partic-
tipating providers in response to their document-
table clinical and financial performance deficiencies;
- As ongoing advisors to top management and direc-
tors of compensation and benefits of corporations of all sizes concerning how to evaluate and continue
to improve the quality and cost-effectiveness of the
health care delivered to their employees;
- As by serving as advisors to employee benefit direc-
tors on how to redesign financial incentives to both
employees and participating providers to promote continuous improvement in both the quality and
cost-effectiveness of their respective clinical decision-making;
- As by serving as chief negotiation agents with partici-
pating providers in continually readjusting reim-
bursement rates to provide ongoing incentives, to
promote compliance with industry developed stan-
dards; and
- As by serving as advisors to providers, purchasers,
consumers, regulatory and accrediting organiza-
tions concerning how the foregoing cardinal prin-
ciples of medical care value purchasing and
enhancement can and should be applied through-
out the American health care delivery system to
continually improve clinical outcomes while saving
enough dollars through compliance with medical standards to expand access to health care without
the need for aggressive new assessments on Cor-
porate America and its employees.

References

6. Cf. Note 1, Chapter 4.