The Life And Health Insurance Medical Research Fund

A Summary

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In 1981, Doctor Lewis Thomas, then chancellor of Memorial Sloan-Kettering Cancer Center, urged leaders of the life and health insurance industry to create a successor to its original medical research fund. The following is what led to his comments.

In 1945 the life insurance industry created a medical research fund that over the following 25 years played a major role in basic research of arteriosclerotic and other heart diseases and funded over 1300 research projects with 26.5 million dollars. Five of the recipients went on to receive Nobel awards. Physicians of ALIMDA and the Medical Section of the ALC (later the ACLI) played an active role in the fund; to be elected to represent one of the two organizations at the biannual peer review sessions was a coveted honor.

Most things change. By 1970, government funding for medical research had increased to an extent that the insurance industry’s support, which was based upon an assessment formula of each company, decreased as the companies elected to contribute to other causes. The fund was discontinued. At this time, physicians from the two insurance medical organizations, particularly ALIMDA, took charge. Doctor Tom Sexton of Massachusetts Mutual led a small group of medical directors who created a fund for the support of MD/PhD scholarships, the Insurance Medical Scientist Scholarship Fund (IMSSF). For a little over ten years, this group solicited money from the insurance industry and provided funds for 92 students to complete their MD/PhD degrees. A fine record for insurance medicine. Studies have shown that these graduates, as well as those from the earlier fund, maintain over 90% retention in academic medicine.

Things changed again. Sources of funding again decreased, costs of tuition and expenses increased. IMSSF was unable to continue. It was a coincidence that about this time, Doctor Lewis was urging more action from the insurance industry. Action occurred, this time from chief executives of some major insurance companies.

A task force was created within the ACLI and HIAA, and after a year or more of study, a recommendation was made to the respective boards of the two organizations: the industry should support a new research fund, primarily for their research and young scientist training programs. The latter would incorporate students still in the IMSSF programs. It takes a while to sort things out, but after about forty years the insurance industry and medical world have completed a circle. We are back with a fund for basic medical research and young scientist training programs; a fine example of the business and medical world working out mutual needs.

There are some significant changes from the 1945 fund. Contributions are now voluntary, not assessed to the companies as before. Four physicians, medical directors from the two insurance groups, are on the board. It is a board that works; it approves policy, encourages and takes an active part in fund raising and makes the final selection of grants upon studying the recommendations of the scientific advisory panel—six scientists acknowledged for their work in research and education. With staff support furnished by the ACLI, the administrative cost of this fund is probably the lowest of any such program; contributions go to the individual investigator, not to overhead expenses.

The cornerstone of the fund’s research programs and potential successes, is the individual investigator. They are first screened and selected by their medical school, and their applications are then reviewed by the scientific advisory panel. Only names of particularly well qualified individuals are submitted to the board for final selection; the number chosen is determined by the amount of contributions. This is a small fund in comparison with many others, and it is not the intention to rival any other sources of research money or activity. Rather the industry seeks through the fund to selectively fill some of the gaps in support of basic biomedical research. Unencumbered by any large bureaucracy, the fund finances promising new investigators who are initiating creative, innovative research. The results have exceeded expectations for this short a time. One reviewer has described the fund as the most competitive of the many he advises, and with the highest of quality individual investigators; several young investigators have achieved national recognition for their work, and the numbers are growing.

The fund is now six years old and has reached nearly $9 million in contributions since 1983. Eighty-five grants are in place and approximately 20 new awards are made annually. Basic research grants are for three years, young scientist training for MD/PhD degrees up to five years. Some special funds are targeted by contributors, usually to specific institutions. The choice of studies is determined by the fund, i.e., The Equitable, BMA, Lutheran Brotherhood young scientist programs, Blake Newton Fund, Nationwide and Columbus children’s hospital, and others. Applications are rated by numerical grading and investigators are in place at most medical schools in the United States. This is good for the insurance industry, as there are companies and clients in all these centers. Letters are sent to each company based near a medical school when their investigator or scholar receives a grant. The work
these days is largely in the area of molecular biology and a significant percentage of research is directed toward cancer and immune disorders.

There is a lot to be done. 700,000 Americans die every year from cardiovascular disease. Over 900,000 new cases of cancer will be discovered and 400,000 of these will die. In addition there is a host of other disorders and unknown numbers of immune disorders. Grants from the fund address all of these problems, many overlap and share common findings. The work being done is truly remarkable, and the future results from these young investigators promises to sort out the causes of these major disorders. Physicians in the field of insurance medicine can be quite pleased with the role of their companies in this remarkable joint effort of basic biomedical research and education.

From The Past

Second Annual Meeting – 1891

At the Second Annual Meeting Dr. William B. Davies, of Union Central Life Insurance Co. read a paper entitled:

ALBUMINURIA IN PERSONS APPARENTLY HEALTHY, AND A CONSIDERATION OF ITS RELATION TO LIFE INSURANCE.

There was a lengthy review of the Causes, Diagnosis and Prognosis. Towards the end Dr. Davis discussed Albuminuria in Life Insurance. The last part of this section was reported as follows:

Dr. Davis called attention to [the] large amount of evidence that albuminuria is not at all infrequent among persons apparently healthy, and that the so-called functional albuminuria does not necessarily end in Bright’s disease. If the conclusions toward which these investigations are pointed are correct, then our attitude as medical officers is wrong and we are doing an injustice to a large class of people by excluding them from the benefits of insurance, and at the same time are doing the companies an injustice by advising them against a class which they might otherwise accept. He pointed out that it was only in recent years that life insurance companies had required an analysis of the urine. We find now only fifty per cent of the companies require it in all cases and one-half of that number have only required it for the past five years. The remaining fifty per cent require it only when the candidate is forty-five years of age or over, and when the amount applied for is $5,000 or over. It was therefore, safe to assume that one-half of the persons assured during the past eight or ten years did not have an examination of their urine made, and practically all who were assured before that period are not subjected to a urine examination. If albuminuria among persons apparently healthy is but the forerunner of fatal disease, and if one-third of the population has albuminuria we would be justified in expecting a heavy mortality from Bright’s disease, particularly among those who were insured without an examination of urine. As a matter of fact, the mortality from Bright’s disease among the American companies for the last five years had been but 5.66%. Hence Bright’s disease did not account for but a fraction of the albuminuria cases met with.

A recent investigation of the medical officers of one of the largest companies represented in our Association shows that Bright’s disease does not account for more than 17% of the cases of albuminuria met with at the home office. The years 1877, 1878, 1879 and part of 1880, show a total rejection of 137 persons for albuminuria. Of that number 57 had died, 11.06% of them from Bright’s disease and 5.84% from heart disease. Crediting all of these to Bright’s disease, we have at the utmost 16.9%.

The evidence of the last fifteen years goes to show that albumin may be found in the urine of persons otherwise healthy, and that cases of albuminuria do not all end in organic disease of the kidneys.