Abstract

The decade of AIDS/HIV has changed the way insurance medicine is practiced by medical directors. One director details some of these changes.

In my office, I have two large roll-out file drawers where I keep reprints, tear-outs from journals, and all the other loose medical data that seem important. The material is stored alphabetically, by topic. The alphabet used to break at the letter L. No more; since the onset of the AIDS/HIV epidemic, I have gradually had to rearrange the two drawers so that now the first drawer contains only A, and the other drawer houses B through Z.

My filing system changes are a small, concrete example of the effect this epidemic has had upon the time, thought and space of one medical director. I have had to radically rearrange all three to try to ensure that my company maintains a clear view of the proper road through this new medical maze. And, because of this, my role as medical director has broadened, not only in underwriting, but, perhaps more importantly, it has also taken on increased presence in our legal, actuarial, marketing, human resources and claims departments.

The title of this article should be Impact of AIDS/HIV on One Medical Director. I don't presume to speak for all of you. The impact of the epidemic on other medical directors has varied, depending upon the size of their companies, their roles in the medical department and the products marketed. Nevertheless, I am sure that most medical directors fulfill jobs that are quite different from what they were before AIDS.

Significant Dates

Over these past years, several events stand out as significant benchmarks on my AIDS/HIV learning continuum:

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<td>June 1981</td>
<td>The Center for Disease Control (CDC) publishes its first article on the AIDS epidemic. This report on five cases of pneumocystis pneumonia in Los Angeles area male homosexuals, I must admit, was recognized by me as important only in retrospect. Even Morbidity and Mortality Weekly Review didn't consider the report important enough to put on the front page, finding a small slot for it on page 2.</td>
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<td>June 1983</td>
<td>The Pasteur Institute announces the discovery of a new human retrovirus, named L.A.V. (for lymphadenopathy associated virus), thought to be the etiologic agent of AIDS.</td>
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<td>1984</td>
<td>CDC and the National Institute of Health researchers estimate that only five to nineteen percent of humans contracting the HIV (as it became known later) virus would eventually develop the clinical disease AIDS. There was a good deal of discussion at this time of &quot;exposure&quot; to the virus causing &quot;subclinical cases&quot; and eventual immunity, analogous to the situation with viral hepatitis.</td>
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<td>March 1985</td>
<td>The first blood test for antibodies to the HIV virus (ELISA) is approved by the Food and Drug Administration (FDA).</td>
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<td>March 1985</td>
<td>Blood bank testing for the presence of HIV antibodies is initiated.</td>
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(These last two events loosened the floodgates of epidemiologic statistics that corrected the misconceptions exemplified by the 1984 CDC/NIH "exposure" theories above.)
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<td>1985 and 1986</td>
<td>California and Wisconsin legislatures severely limit the use of HIV antibody testing for insurance purposes. This served as a wake-up call to medical directors. Risk selection vis-a-vis HIV disease would be different, and considerably more complicated, from other diseases.</td>
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<td>September 1986</td>
<td>The American Council of Life Insurance Medical Section AIDS Committee is formed. This group, I believe, has been an outstanding example of how truly helpful a committee can be to medical directors and to the insurance industry. It has served as a clearinghouse for accurate scientific information. It has not only documented legislative HIV activity of the states, but also influenced the final product in many cases. It has demanded high standards of the labs serving our industry. All its activities have been performed with a genuine concern for the rights of both the insurance companies and the applicants. More on this later.</td>
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<td>December 1986</td>
<td>The National Association of Insurance Commissioners (NAIC) distributes its guidelines on the &quot;proper&quot; content and form for application questions, and many states adopt these guidelines as legislation and/or regulation. The following sentence is but one of many in the publication proscribing certain common underwriting practices: &quot;Neither the marital status, the living arrangements, the occupation, the gender, the medical history, the beneficiary designation, nor the zip code or other territorial classification of an applicant may be used to establish, or aid in establishing, the patient's sexual orientation.&quot;</td>
<td>With the adoption of these guidelines, the underwriting playing field assumed a slightly different shape.</td>
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<td>1987</td>
<td>Randy Shilts' book, <em>And the Band Played On</em> is published. I found this to be a well-written history of AIDS/HIV, written from the point of view of a member of the gay community.</td>
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<td>May 1987</td>
<td>AIDS and Insurance: The Rationale for AIDS-Related Testing is distributed by the Harvard Law Review. This logical treatise by Russell Iuculano and Karen Clifford provided me, and many other medical directors, with the ammunition (and style) needed for the upcoming skirmishes with state legislative subcommittees regarding HIV testing, confidentiality, counseling, etc. I doubt that they will be shocked when I say that I used their words as my own in my testimony before the New Hampshire Legislature. &quot;Insurance is founded on the principle that policyholders with the same expected risk of loss should be treated equally,&quot; and &quot;To ignore the risk levels associated with infection and treat a seropositive individual on the same terms as one not similarly infected would constitute unfair discrimination against non-infected Insureds.&quot;</td>
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<td>August 1987</td>
<td>The Cowell and Hoskins actuarial projections provide another wake-up call for medical directors and insurance companies. Fortunately, their model predicting mid-1990's AIDS losses to be fifteen percent of all claims seems to be a bit on the heavy side.</td>
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<td>October 1987</td>
<td>The FDA licenses the first Western Blot HIV antibody test. This testing sophistication provided a strong tool in AIDS/HIV risk assessment, and went a long way to eliminating the bugaboo of &quot;false positives.&quot;</td>
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<td>1988</td>
<td>Medical consensus has evolved to the point where it is now thought that virtually all HIV seropositive humans will eventually develop clinical AIDS and succumb to it.</td>
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My day-to-day involvement with the AIDS/HIV epidemic has fit into four main categories: Testifying, Teaching, Keeping Track, and Keeping Up.

Testifying

Most of my testimony fit into the earlier years of the epidemic when it was necessary to demonstrate to various legislative committees and other groups that insurance HIV testing was scientifically sound, legally justified, and financially imperative.

The New Hampshire Legislature held hearings on HIV testing and confidentiality, both topics being represented by several proposed bills on the legislative calendar. As noted above, I received a great deal of help from the Clifford and Iuculano efforts on this subject. It fell to me to explain to the committee concepts such as sensitivity, specificity, predictive value and Bayes' theorem. Testifying before a group of relatively unsophisticated citizen legislators certainly proved to be a stimulus to sharpen my definitions and to couch them in terms that were meaningful to the group. Apparently, our efforts were successful, as a testing statute was passed that did not place any large California- or Wisconsin-type roadblocks in our path.

Actually, the confidentiality bill hearings, as they pertained to the insurance industry, were more prolonged and argumentative. The committee seemed openly skeptical when I explained the elaborate routine of confidentiality that had already been established by the industry. I believe my community credentials of having practiced clinical internal medicine and gastroenterology for 25 years finally convinced the committee that I was not merely mouthing self-serving words as a representative of insurance. From first-hand experience, I could point out that strict confidentiality guidelines were much more compulsively followed at Chubb Life than they were in local office and hospital practice.

The confidentiality hearings provided me with a somewhat amusing incident that demonstrated to me the huge emotional impact of AIDS/HIV. I was being questioned about the mailing procedures used by the laboratory to get positive HIV results to me. I withdrew from my briefcase the cardboard special mailer the lab used, and deposited it on the table in front of the committee, saying, "This is a notification of a positive test I received this morning..." Before I could point out that only I was allowed to open the mailer, along with other confidentiality safeguards, the three committee members closest to the envelope withdrew their hands from the table and simultaneously pushed their chairs back about a foot. So much for scientific detachment.

About this time, I was whisked off on two occasions to meet with the board of directors of our parent corporation in New York City. Although never told explicitly, I assume my presentations were intended to reassure them that, yes, the life, health and disability income portion of their company was aware that there was an epidemic in progress, and that, yes, we were practicing safe underwriting.

The next meeting I participated in was not, strictly speaking, testifying. However, I prepared carefully, as I expected considerable detailed cross-examination from this point. The New Hampshire Bar Association was presenting a day-long symposium on AIDS and the Law. I represented the insurance industry, giving a talk on practices and procedures and fielding questions from the audience. At first, it seemed like an excellent forum for some of my better lawyer stories. However, the gravity of the subject and the lawyer:doctor odds (250:1) made me decide to be circumspect.

I had expected to field highly technical and complex queries from my audience and was therefore quite surprised to realize that they needed coaching in very basic insurance concepts. It was necessary to point out that there are some basic differences between health and life insurance. And that insurance companies would not rescind an in-force life policy if the Insured subsequently became HIV-seropositive, even if the company were legally able to rescind. This experience has taught me not to presuppose any level of medical or insurance sophistication in any audience.

Teaching

I have always considered teaching to be the highest possible function of an insurance medical director. This epidemic has made it mandatory to be an effective teacher. The first person I found it necessary to teach was myself. This was no easy matter. For those of us who went to medical school during the middle ages, it has been a daunting task to develop familiarity with and understanding of such concepts as immunosorbent assay, recombinant DNA technology and polymerase chain reactions, not to mention the whole complex field of human immunology.

Next came the underwriters. At our weekly education sessions, we developed a strategy designed to develop recognition of red-flag opportunistic infections, tumors, medications, etc. Publications within the industry help immeasurably with this task. Quite a fine tightrope has been necessary to negotiate the chasm of adverse selection, while at the same time adhering to the NAIC guidelines. Similar conferences in our claims depart-
ment have, hopefully, alerted those examiners to the fact that a death from, say Mycobacterium aviumintracellulare equals AIDS/HIV, and must be so designated for the sake of accurate record-keeping.

Teaching of a different nature was instituted for all our employees in 1988. A company-sponsored movie was shown, followed by a question-and-answer period with the medical director. All employees also know that I am available on an individual basis to discuss HIV-related personal problems.

The most emotionally draining aspect of teaching, of course, has involved applicants with positive tests, their spouses and contacts and their personal physicians. We in insurance medicine always make a big point of saying that we are in the "risk assessment" business, and not in the "diagnostic" business. This fine point is, inevitably, lost amongst the unfortunate people intimately associated with HIV seropositivity. I'm sure that I speak for most medical directors when I say that these phone calls are extremely difficult. Maintaining a humane mien whilst at the same time fulfilling my medical and legal obligations provides me with my most trying moments.

Keeping Track

It has been amazing to me that my company (and other companies also, from what I hear from my fellow medical directors) has made AIDS/HIV the medical director's baby. We are expected to maintain accurate statistics regarding testing, claims, etc., and to recommend underwriting, marketing and pricing policies that reflect reality in the midst of this epidemic. This expanded role is certainly in marked contrast to our traditional roles in decision-making regarding old and established diseases, e.g., cancer and heart disease. It is often difficult for the medical director to get a thought in edgewise with these old familiar conditions. It is almost as if the actuarial staffs have recognized their lack of adequate model to project mortality and morbidity for a universally-fatal disease with an 8.2-year "incubation period."

For the first time, it seems, the medical director is playing the major role in determining what test to do, at what policy level, in which states and territories. And, he must also compare his claims experience with other companies and the industry as a whole. The increased responsibility is both challenging and rewarding.

Keeping Up

There are so many articles on AIDS/HIV, not only in medical journals, but also in the lay press, that the doubling time for information seems to be about six months. I guess this is why my file cabinets are so full. It is incumbent upon us not only to be aware of the HIV field of knowledge but also to put ideas and data in proper perspective. Otherwise our advice to our various departments (underwriting, legal, claims, marketing, human resources, etc.) will be detrimental.

A major factor in my keeping up has been the ACLI Medical Section AIDS Committee. It has been a great privilege to serve on this committee with such people as Drs. Don Chambers, Dick Bailey, Bob Gleeson, Ernie Bullock, Bob Pokorski, and Curtis Lasix. I'm sure that I speak for most medical directors when I say that these phone calls are extremely difficult. Maintaining a humane mien whilst at the same time fulfilling my medical and legal obligations provides me with my most trying moments.

AIDS Maze,11 the ACLI compendium of legislation and regulation of all states, has made the job of keeping up on a legal level much easier.

Conclusion

The role of the medical director and the underwriting department had already started to assume more importance to insurance companies before this AIDS decade began, because of changes in interest rates, investment opportunities and business philosophies. Nevertheless, the advent of HIV infections in humans has hastened this evolution. The decade of AIDS/HIV has been one of challenge for medical directors, but it has been a challenge met squarely and decisively. Companies have failed during this decade because of junk bonds, commercial real estate and shaky business practices. But none, as far as I can determine, have failed because of AIDS.

References


