JOURNAL OF INSURANCE MEDICINE

EDITORIAL

Organized Medicine and the Life Insurance Industry

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Among the reasons for consolidation of the life insurance industry is the changing focus of the customer. Fifteen years ago, Americans bought 17.7 million new life policies; last year they bought 11.1 million.[1] Sternberg in the Opinion Section of this Journal, commented that the biggest threats to our industry are the "entitlement" threat and the issue of genetic testing.[2] In this climate, how can we differentiate our products so that they only are attractive to our customers, when the industry moves more and more toward a low cost commodity-like term product?

We, the Life Insurance medical directors are *ipso facto* the links to our professional colleagues, the physicians. After all it is the physician who in his/her own way performs an assessment of their patient and develops an action plan which may or may not result in further examinations and tests or treatment strategies and has certain influences on both morbidity and mortality. We can communicate with physicians, individually, through discipline or interest group or through the American Medical Association, the foremost organization for the physician which represents all physicians.

The most important issues currently affecting our industry which have impact on physicians are genetic testing, risk stratification, confidentiality, coding issues, standardization/medical records issues, ethics, the Medical Information Bureau and fraud. But first we must accurately communicate to our colleagues who we are and what we do.

The Role of Life Insurance Medical Director.
In general our industry does not rank highly in the public perception and particularly in the eye of the practicing physician. Physicians, unfortunately for the most part are unable to distinguish the roles of the medical officer of a life insurance company from the role of the medical director of a health insurer. We have a challenge to introduce ourselves and our roles both individually and corporately to the "House of Medicine", that is the organization which comprises the entire American Medical Association, the House of Delegates, the Board of Trustees, the Councils and staff. At the turn of the last century, it was the insurance medical directors who first used widely urinalysis as a screening tool. Subsequently we were involved in the development of blood pressure measuring as a method for stratifying risk. Screening for diabetes mellitus, heart disease, AIDS testing and hepatitis all owe their widespread introduction to use by the life insurance industry. In the future it is likely that we will use screening for homocysteine and other markers of cardiac disease potential.

We need to explain to the practicing physician that we have much in common. The science of mortality ratios is similar to the clinicians' approach to clinical medicine. An integral part of outcomes measurement is in fact, analysis of the "observed" death rate. From this and the knowledge of "expected" death rate or best practice in clinicians' terms, we can calculate the mortality ratio that are both age and sex matched.

Genetic Testing Issue.
On the one hand we applaud the scientific community for its amazing discoveries in the human genome project, on the other hand we have no idea how to use the information and

relate it to specific death rates in individuals. There are of course certain genetic abnormalities that are associated with specific disease and we know the natural history of that disease. The life insurance industry in general and specifically the medical directors should be involved in the development of a code of ethics for genetic testing to include basic points such as, applicants (for life insurance policies) should not be asked to take a genetic test. Insurers should have access to the test results, if they have been performed by others and insurers should use the results fairly when setting premiums or declining an application.

The life insurance medical directors must speak convincingly at the annual, interim and special meetings of the American Medical Association to further their recommendations on genetic testing. By communication of the substance of our arguments we may at least be able to head off the House of Medicine testifying, state by state, for onerous, and unworkable, genetic testing legislation.

Risk Stratification.
Several of the points, to be made about the fairness/unfairness of risk stratification have been made above. The principle difference is that we, the life insurers, believe that we are entitled to have the same medical information as the applicant. If medical information, including genetic tests are not revealed to us then there is a fairness issue that can be applied to all those applicants who declared honestly their medical condition and to those in preferred categories who have to pay more for their premiums because of adverse mortality. We, the industry, believe that risk stratification is the one element of life insurance which preserves it as a voluntary product and allows it to be affordable for the majority of applicants.

Confidentiality.
We, the insurance industry, believe strongly in the fact that the medical records of an applicant for a life insurance policy be kept confidential. Not only do we request a release form for the release of the medical records from the physician concerning his or her patient but we also send our screening results to the applicant and if they specifically request it, we also send the results to their personal physician. We staunchly believe that the medical records belong to the patient and at their wish and consent can be sent to a life insurance company. We do not believe that there should be a second record that is secret and contain the results of genetic testing and psychiatric consultation.

Coding Issues.
Expenses and losses may be a fine distinction to most practicing physicians but to the insurance industry they are not only important but by law insurers are required to differentiate the one from the other. Through intensive committee work the representative of the insurance industry on the American Medical Association Current Procedural Terminology Advisory Committee, authored a section of evaluation and management codes which apply specifically to the life insurance industry. Subsequently these codes were accepted by the Editorial Panel and now they are published in the yearly update of the codes.[4]

Standardization/Medical Records Issues.
Many of the resolutions proposed at both the annual and interim meetings of the House of delegates of the American Medical Association contain resolves that relate to the standards for medical records and the standards for transmitting those records through internet or intranet systems. We push for consistency of medical record and for the ways in which we may receive it.

Ethics.
The American Medical Association believing that one of the hallmarks of a profession was to take a lead in the area of Ethics founded and "Ethics Institute" within its organizational framework. Indeed one of the American Medical Association's three core values is "Integrity and Ethical behavior: the basis for trust in all relationships and actions". This translates to the objective, namely, "The acknowledged

leader in promoting professionalism in medicine and setting standards for medical ethics, practice, and education". The life insurance industry as part of the House of Medicine, agrees with these statements and a strategic goal of the American Academy of Insurance Medicine states, "Promote the highest standards of ethical behavior within the insurance medicine and fiscal responsibility within the Academy". In a self-serving way, we applaud the American Medical Association as it promulgates ethical standards and as it points out to practitioners that it is not appropriate to alter or in any way change attending physician statements to the benefit of their patient and our applicant.

Medical Information Bureau

Few clinical physicians have an idea as to the role and the function of the Medical Information Bureau (MIB) an organization which has been in existence for nearly 100 years. It is a not-for-profit organization with 650 members who are life insurance companies. From time to time there are resolutions that appear in the American Medical Association House of Delegates which relate to the Bureau. These generally stem from a lack of knowledge and are derogatory in nature. It is our responsibility to explain that the Medical Information Bureau was started, in part, to protect life insurance companies from fraudulent applications, the philosophy being that if the applicant had had a medical test, then the insurer to who the application for insurance was being made should have access to that information. The other functions of the Bureau include a disability insurance record system, an insurance activity index and a health claims index. There are specific rules which pertain to reporting, using codes, appeals etc. We should also indicate the importance of the MIB studies that provide clinical information through the Center for Medico-Acturarial Statistics (CMAS).

Fraud

The greatest abuse and fraud which we the insurance industry have to face is medical fraud and insurance fraud involving the medical provider. Fraud can be divided into "known" fraud, which is fraud that is expected and awaits counter measures and "unknown" fraud which because it is unsuspected, there is no easy way to measure it let alone prevent it. As an organization, the American Academy of Insurance Medicine has supported an all payor working group to determine the nature and extent of medical fraud and insurance fraud involving medical providers. This move that has involved the American Medical Association at the very highest level, to participate in the study. An answer, except in the most egregious of cases, is education rather than criminal prosecution.

Having enumerated some of the profound issues facing the life insurance industry, how can the industry impact the House of Medicine and what has the House of Medicine got for the industry? It is the House of Delegates that determines policy and elects the physician leaders. Policies are determined by debate both in Reference Committees and upon the floor of the House of Delegates. Issues are developed by elected councils such as Medical Service, Scientific Affairs and Medical Education. Other councils are appointed such as the Council on Ethical and Judicial Affairs and Long Range Planning and Development. The Board of Trustees acts as a board of directors, but all the members are elected by the House of Delegates. The Speaker of the House and the vice-speaker are *ex-officio* members of the Board of Trustees. The Board elects its officers and the House of Delegates elects the President-elect of the Association. The Board appoints the Executive Vice-President of the Association.

To become one of the 484 delegates one must have the support and trust of a significant body of physicians. The majority of physicians, 340, in the House of Delegates, at this time, come as elected members of a state delegation. Each delegate represents about 1,000 members of the association. To become an elected delegate, it is often the culmination of years of service at the county and state levels before one gets the recognition of ones fellow

physicians to represent their views at the House of Medicine.

Reference Committee testimony and speaking from the House of Delegates floor are not the only opportunities that the coalition representing the life insurance industry use. For instance, the AAIM delegate addressed the American Medical Association State Health Legislation meeting in January 1998 on important issues facing the life insurance industry, and another of us has made three one hour presentations to the Board of Trustees at their regularly scheduled meetings on issues facing the insurance industry and how the American Medical Association can work with us.

Conceptually, we the physicians of the life insurance industry have three levels towards which we should focus our efforts. The first is the local level, the County Medical Association and the State Medical Association. We can educate our colleagues. We can carry resolutions, behind which we stand to become policy of the House of Medicine. We can pre-empt inappropriate policy resolutions from moving from state to the American Medical Association House of Delegates. At the delegate level, we can form coalitions, we can develop support for an industry and we can promulgate good policy and avoid the bad through both oral and written communication. These coalitions may be formal, such as the Preventive Medicine Council or informal. It is the latter which is perhaps the most important feature for it gives one the ability to network with AMA staff, or delegates. The latter group consists of leaders in the medical field, deans from medical schools, editors of prestigious medical journals, Surgeons General of the Air force, Army and Navy as well as the US Surgeon General, many presidents of physician specialty societies and so on and so forth.

At the organizational level, the Academy of Insurance Medicine can put on educational meetings, publish an influential journal and work as a participating organization in the House of Medicine. Let us never loose the sight of the fact, that the organizational structure allows a few physicians in life insurance medicine to influence the House of Medicine. What a huge return on investment. For the few of us can influence an organization, with an annual expenditure of over $230 million and one of the most freely spending organizations for the elected representatives, senators and state legislatures, which wields great political influence at state and federal level.

So, in conclusion, it is extremely important that there is a lively interchange between the life insurance industry and the American Medical Association. The Association has a very strong Washington impact and influence. The state societies regularly interface with state legislatures, not to overlook the fact that most elected representatives have personal physicians! In order to liaise with organized medicine, the few physicians that are active with organized medicine need to be encouraged and supported, for it is much easier to be involved in the creation of prospective policy, rule and regulation, than it is to have to take the fight to fifty state houses and try and get changes. In the House of Medicine there is a chance that reason will prevail, physician to physician. It may be hopeless when representatives from our industry line up in the hearing room against, the local physician and activist for life insurance as an entitlement, and even worse when that physician brings a genetically disabled sufferer from Huntington's chorea or a young man with inherited muscular dystrophy.

References

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