The Role of the Medical Director in the Risk Assessment Process

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dical directors’ activities support the life insurance industry’s continued ability to rely on the risk assessment process. Activities that support risk classification from a legal perspective and provide an insurer a defense to lawsuits before they reach the trial stage also promote the professional development of medical directors. Providing information that helps meet the demand for fair, nondiscriminatory underwriting for consumers, proposed insurers, applicants, regulatory agencies, and public advocacy groups are also integral to the support of the risk assessment process.

Metrics that assess the professionalism of medical directors can be derived from expert witness criteria. These are criteria that all courts use to admit someone as an expert witness. Courts view an expert witness through two components: the methodology used by the expert and the actual expertise of the individual. US Federal Courts use the same basic criteria to determine if someone is an expert witness. Most of these criteria are directed towards the methodology used and not necessarily the individual expert.

The mnemonic, TRAP, summarizes the criteria a judge uses to determine whether a witness qualifies as an expert:

- T: Has the methodology used by the expert been Tested?
- R: What is the known or potential Rate of error of the methodology?
- A: Is there widespread Acceptance of the methodology by other experts?
- P: Has the methodology been subject to Peer review and Publication?

Most states use additional factors. As an example, Texas uses two additional factors, and the mnemonic becomes “TRAP-ON”:

- O: Does the methodology have Objective vs subjective interpretation of the data involved?
- N: Are there Non-judicial uses of the methodology?
Methods that are more objective, more quantitative, and lead to black and white interpretation of the data tend to have a greater credence in court than those that are subjective and subject to opinion. Methods that are only used in the courtroom setting are not given as much weight as those that are used in real world situations.

If all six of these factors are distilled down to their base elements, there are two basic ideas. First of all, the credibility of the witness is based on the methodology used by the expert witness, one that is scientifically proven to be accurate with a high degree of accuracy. Given the same set of facts, the same circumstances, will that methodology produce the same answer time and time again? Then, in regards to the expert as an individual, does the expert understand the theory behind the methodology, and is the expert able to apply the methodology to factual and hypothetical situations? In other words, does the expert know what he or she is talking about?

Do medical directors meet criteria of an expert witness in their daily participation in risk classification activities? Let’s review these point by point.

The risk classification methodology consists of a numerical rating system developed approximately 85 years ago. Since that time, it has been extensively tested and validated in the scientific and actuarial communities. Cost-benefit analyses that I saw as an underwriter indicated that the underwriting requirements used were valid for protecting an insurance company and for enabling assignment of risk. From the legal standpoint, I think risk classification meets the criteria of a tested methodology.

There are two main components to rate of error in underwriting. First is whether the latest improvements in mortality and morbidity are reflected in the rating criteria. Although companies attempt to include the most current information to keep rating manuals current, inevitably some old information may be retained in manuals used by some companies. Using old information will potentially increase the rate of error, possibly to an unacceptable level.

The second component concerning rate of error is whether the medical director is correctly applying the numerical rating system. As an attorney, this is important to pursue, and I am going to look at two aspects. First, the course taken by the medical director prior to entry into the profession. The majority of medical directors today tend to be cardiologists or internists, which makes sense because the majority of the most frequent impairments come within that purview. That does not mean that an orthopaedic surgeon can’t be a medical director, but an attorney is probably going to have an easier time showing that an orthopaedic surgeon is not as qualified as a cardiologist or internist to be the medical director, and thus, potentially less able to make sound risk classification decisions.

Continuing education and the availability of training programs for risk classification and mortality are also important considerations. More important than availability, are all medical directors participating? If I am going to depose a medical director, I’m going to determine whether she or he has attended any of these avenues of learning. If not, I am going to use that as a strike against them. Certainly to me, for any profession, the greatest source of continuing education is doing the work on a day-to-day basis to build personal knowledge. From an attorney’s standpoint, continuing education is working on cases to build expertise in a particular impairment, developing the ability to apply theory to fact, and reading journals on a regular basis to stay up to date on the impairment.

From a legal standpoint, an acceptable rate of error of the methodology is one area an attorney will look to shoot down either the risk classification process or the expert witness. I bring this up to you because no matter how good a physician or medical director you are, if I can prove that the methods you are using are not as good as they should be,
I do not have to worry about proving you are not an expert. If I can shoot down your theory, that makes it much easier for me to get my point across to a jury and to the judge.

Risk classification has been extensively validated in the scientific and actuarial communities and meets the criteria of acceptance by experts. From all the court cases I have read, there is certainly judicial acceptance of this process. But, there is only going to be continued judicial acceptance of this process if we can show that the ratings we develop, or the reasons to decline coverage, have a statistically valid basis. I think the risk assessment process is on fairly good ground with respect to acceptance by experts.

Peer review and publication includes production of research papers, mortality studies and medical abstracts. I used to be a regular reader of the Journal of Insurance Medicine, and it improved my ability to underwrite a case and my ability to revise medical manual sections. I am probably preaching to the choir in terms of the need for producing these, but there does not seem to be enough of that kind of activity going on in the industry as a whole.

I have pointed out to the underwriters that they also need to get more involved in these activities. An attorney will look toward the underwriter as the primary witness, since he or she is the one that actually underwrote the case and made the decision. Yesterday, I spoke to a group of 400 underwriters and told them I always read the Journal of Insurance Medicine, and it improved my ability to underwrite a case and my ability to revise medical manual sections. I am probably preaching to the choir in terms of the need for producing these, but there does not seem to be enough of that kind of activity going on in the industry as a whole.

There has always been a debate whether underwriting is an art vs a science, or objective vs subjective in the mnemonic. If an underwriter gets on the witness stand and responds to the question, “what is underwriting,” by telling me that half of us think it is an art and half of us think it is a science, it will be easy discrediting their arguments. Ideally, a response should be along the lines that underwriting or risk classification is a profession based upon sound actuarial principles. In other words, define risk assessment and underwriting in terms of the goal of the process, specifically correctly quantifying insurance risks.

Furthermore, convince underwriters that they should be engaged in similar activities so that they are all working as a team to be better informed about impairments they are underwriting. Professionalism is proactive. Information and education does not come to you, you must go to it, and it is a career long process. More intense exposure to actuarial sciences may also be beneficial to underwriters.

The key goal for medical directors and underwriters to keep in mind is to continually work toward improving your ability to price risk. This certainly includes continuing education, such as attendance at annual meetings. But it also includes active participation in continuing education programs for underwriters, either giving a presentation or helping provide the resources and the background to teach underwriters. Foremost, it involves your continuing participation in the production of articles, abstracts and mortality studies. I do not believe you can ever produce enough articles, abstracts and mortality studies to serve as resources for correct assessment of risk. It is not possible to get to the point where everything has been covered, because as we all know, over time things change in medicine, new things arise, and different ways of thinking come about.

All of these activities serve to continuously test, validate, and expand the methodology that medical directors practice in their day-to-day activities. Day-to-day participation in
these activities serves to demonstrate an individual medical director’s ability to understand and apply the methodology upon which the industry’s risk assessment process is based. Meeting courtroom expert criteria can go a long way towards serving as useful guides to daily activities in the life underwriting office setting.

Editor’s Note: Based on a presentation given to the American Academy of Insurance Medicine at Denver, Colorado, on October 6, 2004.