INSURANCE MEDICAL DIRECTORS
DIRECTIONS FOR THE FUTURE

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"Orange juice isn't just for breakfast anymore." I have no idea how effective this slogan was. But the idea of *new uses for old resources* is upon us in Insurance Medicine as well as in the corporate environment in general.

The question for us is, "Can the old dog be taught new tricks?" And, another even more important question, "Will anyone notice ?"

Insurance Medical Directors have carved a place in history and in the very hearts of life insurance companies. The long tradition of ALIMDA speaks to the necessity, the staying power, and the importance of medicine to the business of life insurance.

Much of what we did in the old days by virtue of education, training, and experience has now been codified and published. The case which does not fit the description in the book still is with us, however, and appears on one of our desks each day. The competitive company that desires to remain in the life business demands quality professional underwriting opinions from the medical director.

Our underwriting experience is now being harnessed through expert systems to leverage us. Despite the strides that are being made in the whole field of artificial intelligence, it seems likely that they will provide, if anything, too much consistency. It will still be up to the individual medical director to be a final arbitrator, the referee to balance medical knowledge, actuarial tables, and the business into a decision that may be unique and confer a competitive advantage.

There are many new tricks we old dogs must learn which will help our companies be still more competitive and, in fact, may help our companies survive the successive shockwaves of the future.

The future for business in the U.S. and Canada depends ever more on successful competition in the global marketplace. It is no longer sufficient to delude ourselves that a business of selling life, disability, personal, and commercial lines insurance is utterly independent of manufacturing in North America. We sell insurance to those who are in manufacturing and to businesses that do compete in a global economy.

Shockwave number one is upon us and it is called the "spiralling cost of health care." This upward-bound cost affects us all. We are responsible for our employees' health care in retirement. Our employees' health care costs during employment must be paid. Health care for the dependents of employees must be funded.

We who sell health insurance are not much better at controlling our own health care costs than industries and businesses that have nothing to do with the finance of health care. Our companies are engaging in new forms of business by involving themselves with HMOs, PPOs, Point of Service Networks, Centers of Excellence, and other strategies to control the claims cost of medical care. All of us will have to learn something about managed care and some of us will have to learn everything about managed care.

TRICK NUMBER ONE: Learn and apply principles of managed care, both internally and externally.

The external environment for managed care: The application of cost containment techniques in the products we sell is now familiar to all of us. If the company you work with is not applying some cost containment discipline (Utilization Review, Provider Contracting, Bill Audit, etc.) to the health insurance line of business, then there may be some degree of job insecurity in your future. We must go further and integrate our case management/rehabilitation techniques into the mainstream of health care delivery to develop managed care products.

Managed care has increased by giant steps in the last few years. Many insurers employ a variety of techniques to manage their health care lines. The growth and development of HMOs, PPOs, and other arrangements are indicative of a move toward managed care in controlling health care claims costs. Property and casualty insurers are now at last beginning to understand the potential of managed care as they compare the growth in claims costs of repairing windshields compared to the growth in claims costs associated with medical care, hospitalization, and durable medical equipment.

We medical directors should have a clearer understanding of the dynamics of cost shifts from the "managed" health care payors to the "unmanaged" automobile medical and workers' compensation payors than anyone in the company. We medical directors will have to lead the process of introducing managed care into the property and casualty environment.

The internal environment for managed care: In an effort to stem the medical cost expense tide in our employee health plan, we need to introduce managed care to our employee health service. Data is becoming available that attests to the value of wellness programs at the worksite. Smoking cessation programs, hypertension discovery and monitoring programs, cholesterol reduction, weight reduction, andstress reduction seem reasonably well established. And, mammogram screening, prostatic specific antigen screening, and prenatal care programs all show promise of further containment of employee health care cost and, more importantly, enhancement of employee productivity.

It makes good sense to maintain our human resource with at least as much care and concern as we maintain our fleet of company cars. Some businesses are operating a company clinic and others are exploring the possibility of doing so. No one in the organization knows more about the delivery of quality medical care than the medical director.

Shockwave number two has to do with the spate of legislative initiatives on the horizon that would change the health care delivery and financing system in the U.S.

While the system in place in Canada works reasonably well for Canadians, and the system in place in the U.K. works reasonably well for the British, and the system in place in Germany works reasonably well for the Germans, wholesale import of any of these to the U.S. should be approached with caution. Features of each may well be worth incorporating in the restructuring of the U.S. system.

Make no mistake, the system will be restructured. Pressure from the patient/public confused by multiple bills, explanation of benefits, and reimbursement wrinkles will demand reform. Advocates for the poor discouraged about our infant mortality rate, our spotty prenatal care, our crisis care modality for routine care of the poor, the morass of conflicting medicaid requirements, schedules, and poverty determination levels will lobby for reform. Business will support reform out of concern for rising costs in hopes that the costs may be distributed differently. Labor will support reform out of concern for diminishing benefits as employers shift cost to employees.

TRICK NUMBER TWO: Become the advisor to the company's Government Relations Department on how to influence reform in a way which preserves the best of what we have developed in health care as a nation as we legislate and regulate to prune out the parts which don't work well at all.

We medical directors may not have the most broad or all encompassing understanding of the political process or of the problems with delivery and finance of health care but we have an unique perspective. We are among the few who understand the mixed feelings of the physician provider who has the best interest of the patient in mind and at the same time is trying to hold onto a respected and cherished place in the social, cultural, and economic scheme of things. We have a sense of what will work from the physicians' point of view and what will not work in the best interest of the patient.

On the other hand, we medical directors can recognize an economically driven, less-than-caring, over-utilizing, profiteering medical practitioner. We have the opportunity and the obligation to provide balanced counsel and to provide testimony at legislative hearings.

The third shockwave approaching, if not already here, is the wave of increasing litigiousness. The tort process in the U.S. is a costly, inefficient system that may not work in the best interests of those whom it purports to serve. The "lottery" mentality pervades every level of society and is costly in medical liability costs, defensive medical practices, accident settlement costs, and worker's compensation premium costs.

TRICK NUMBER THREE: Train and help prepare the trial attorneys working for your company in the subtleties and facts of medicine so that the defensive position of the company is strengthened.

We medical directors know medicine and we know what is good and necessary medical practice when we see it. We can spot treatment for a non-accident-related condition in milliseconds and, upon such revelation in court or in pre-trial, the bargaining position of the litigant is reduced.

We have access to data about reasonable medical charges for procedures and about reasonable diagnostic approaches to problem solving and we are in position to blow the whistle when appropriate as we see medical costs being inflated toward increasing the total settlement. We need to understand the law and its practice.

We operate from the bias that fairness equates with justice. Attorneys, ours and theirs, operate from the bias that justice, what the judge and jury decide, equates with fairness. Someplace in the middle is the truth that fair is not always just and just is not always fair. Once we learn the rules of the process, we can be of great help to our legal brethren as they prepare to do battle.

The fourth shockwave building is the issue of our employees' safety and health. The Occupational Safety and Health Administration (OSHA) is not only a concern for the meat cutters and the asbestos workers. OSHA is everyone's concern. The video display terminal, the computer keyboard, micro-film copying processes, side-stream cigarette smoke, reasonable accommodation for Americans with Disabilities, The Drug Free Workplace Act: These are all titles and phrases that signal the potential for adverse expense in operations of our companies.

Clearly there are legal dimensions, managerial dimensions, facility cost dimensions, human resource dimensions, and others which extend beyond the confines of the medical department, but we owe our companies our expertise and vantage point.

TRICK NUMBER FOUR: Develop an understanding of occupational medicine.

We medical directors stand at the interface between our employees and the company and must have both "clients" in focus as we operate at that interface. Diana Chapman Walsh[1] refers to this dimension as "doctoring for the situation," drawing an analogy to Justice Louis Brandeis' notion of "lawyering for the situation" when his ethics were being scrutinized in 1916.

At the risk of being considered an alarmist, we must alert our managers to potential liability extant within a 4-foot radius of each one of the hundred VDTs on each of our operating floors. The screens are not emitting a great number of rads of energy; the rods and cones are not deteriorating by the tens or hundreds; the carpal tunnels are not becoming symptomatic minute by minute. But, if the issue of concern for our employees gets away from us, it may be that all of the above are true.

A significant number of the working public does have demonstrable carpal tunnel pathology. Undiagnosed visual problems are quite common in the young working-age population. If eyes change or fingers fatigue in an environment of non-concern and non-accommodation for optimum comfort, there is little doubt about the cost implication.

The sensitivity of occupational medicine is the process of adapting the job and the job environment to the individual, rather than making the individual adapt to the job.

And, finally, the fifth shock coming is the increasing inability of all of us to communicate across disciplinary boundaries. "Insurance-speak" is a language we had to learn upon entering the insurance medicine field along with the disciplines of underwriting, review of claims, and the like. We may not even realize we are multi-lingual and that our knowledge is also multi-dimensional. There are significant misunderstandings between and among the important players in the big arena of health, law, politics, medicine, and consumer movements.

TRICK NUMBER FIVE: Expand on this multi-linguality and interpret across the barriers between disciplines.

Can we old dogs learn new tricks? Yes! Will anyone notice? Not if we retreat to and remain in our traditional technical role. There is nothing wrong with the traditional technical role. Orange juice remains good for breakfast, but for many of us there is a new set of challenges available to the Insurance Medical Director of the 1990s.

REFERENCE

1. Walsh DC. Is There a Doctor in the House? Harvard Bus Rev 1984 (July-August):84-94.