

## The Role of the Medical Director in a Life Insurance Company

Nigel K. Roberts

This title sounds rather restrictive. It is and it is meant to be! Of the 700,000 licensed physicians in North America fewer than 500 are full-time medical directors for life insurance companies. Many more have broader corporate roles as employee health physicians, medical director of health insurers or as providers of medical care for segments of the community. Others are involved in disability, long term care, claims review, risk management, loss control and a variety of other lines of business. However, I want to focus upon what a life insurance medical director traditionally did, what a life insurance medical director does and what a life insurance medical director could do for a life insurance company.

Essentially the role of the industry is to produce a product which protects a policyholder's financial responsibilities from the impact of premature death. There are many products which are variations on this theme but all require an estimate of the life expectancy of the proposed insured and all are priced to recognize the covered risk. Some, in the case of the impaired risk annuity, have almost the opposite principles. In other words those with a risk of a shorter life through disease or unhealthy lifestyle, e.g. cigarette smoking, may actually have a lower premium.

Therefore, in bare bones terms, a life insurance company manufactures a product from knowledge of observed versus expected death rates, and the expected cost of capital over time. For this product to be successful, it needs to be advertised, marketed and sold in quantities large enough to amortize appropriately the risk. The policy needs to be underwritten in terms both of financial affordability to the

applicant and on the applicants risk for premature demise. The risk, in certain situations needs to be spread out through reinsurance. The assets that back up the policy need to be managed in a prudent way.

The Association of Life Insurance Medical Directors of America (ALIMDA, renamed the American Academy of Insurance Medicine in 1991) was formed in 1889 and is one of the few medical specialty societies which shortly will span three centuries. Prior to the 1980s life insurance medical directors, in general, worked very closely with the medical underwriting teams and were able to use the vast experience that was being collected on medical conditions. Dr. Harold Frost suggested a number of years ago that there were three periods of history to the profession<sup>1</sup>. The first, the empirical period was up until 1905, the second era was the bio-statistical period from 1905 - 1930, the third from 1930 to the current time, namely the clinico-biostatistical period. Perhaps as the end of the 1990s occurs we are entering yet another period, the techno-clinico-statistical period.

Although, medical examinations were performed on insurance applicants in the late 1700s, it was in the early 1800s when medical underwriting was formalized. Routine urinalysis was initiated as an underwriting tool preceding use in clinical practice. In 1905 Dr. Oscar Rogers, Medical Director for New York Life, along with the company actuary, Arthur Hunter developed the numerical rating system for substandard lives. Dr. Rogers also introduced the sphygmomanometer.

The clinico-biostatistical period has seen the

1939 Blood Pressure Study, 1959 Build and Blood Pressure Study, 1976 and 1991 Medical Risks and the Medical Selection of Risks, a series which started in 1962, with additional publications in 1977, 1985 and 1992. All of these studies allow an ever more specific classification of disease and co-morbid conditions which affect life expectancy but generically there were only two types. The first from the insurance industry using the vast amount of clinical data derived from applications and the second from clinical studies. For instance, at a meeting in 1965, there was an attempt to bring the clinical experience of the most prominent pediatric cardiologists to bear on the natural history of congenital heart disease with a group of life insurance medical directors. It was notable that in terms of outcomes, it was the life insurance medical directors who had the data to support or refute the anecdotal observations of the clinicians. The reason why, one of the life insurance medical directors explained, "During the course of an entire lifetime you might see a few thousand patients, whereas in one company in the month of April, we averaged approximately 1,800 applications a day."<sup>2</sup>

Times are changing. In clinical medicine accountability has taken on a different meaning. It is no longer satisfactory to be certain that the structure and process are key. Outcomes have to be measured. Health plans are being judged on how they treat patients and upon their outcomes. Among other criteria, employers select health plans on outcomes. Differences in treatment and management strategies will become crucial in the underwriting process.

Taking for example, a recent report in the literature, the authors conclude that if percutaneous transluminal angioplasty (PTCA) is performed by a cardiologist who does fewer than 75 procedures a year, the mortality may be 33% higher<sup>3</sup>. This however should not be taken in isolation for that physician has a greater frequency of PTCA cases going to surgery (3.93% vs 2.84%) and if the surgical

mortality rate is 5% at a low volume center compared with 2% at a high volume center, there will be an increase in 50% in the mortality rate between a high volume PTCA expert working in a high volume hospital compared to a less experienced physician in a low volume site. In other words the quality of the care and treatment becomes a differentiating point in identifying those at higher risk for premature mortality.

By 1981, ALIMDA had sensed that the industry was diminishing the traditional role of the medical director and they charged a committee to identify and define an appropriate role for physicians as medical directors in the corporate structure of an insurance company. The committee identified six problem areas which included: a lack of understanding of the financial structure of the industry rather than their specific company alone, varying interests of the medical director, the role of training the lay underwriters, the future of underwriting in the industry, management skills of the medical director and the structure of the professional organization, ALIMDA. By 1997, the problem areas have been addressed.

Today the role of the medical director in a life insurance company is usually defined narrowly as one with the ultimate medical authority in the medical underwriting arena. He or she is charged with being at the cutting edge of medical innovation so that the risk can be assessed most aggressively to be fair to the proposed insured and at the same time providing a competitive quote in order to win the business. At the same time the medical director must have a degree of realism that prevents the company from sustaining an inappropriate number of claims. This role has evolved from the empiric period when a medical director used wisdom and experience, to the bio-statistical period, when the industry collected and reviewed large amounts of data generating this from blood pressure measurements, electrocardiograms, x-rays and urine testing, to the clinico-biostatistical time. In this era the age and gender matched data could be

turned into mortality ratios which can be translated into the setting of an appropriate premium.

We are, now, in the era where we can work with our fellow physicians and those entrusted to look after populations of people for the efficacy of their treatment programs in prolonging life. To do this we must interface as never before. Characteristically there is a tendency to confuse the life insurance medical director with the other medical directors that "give permission" for some procedure or treatment strategy. Today, we are on the same side as the clinician. In fact, seldom a day goes by in most companies when we do not aid the treating physician. We alert them to unknown hypertension, to unsuspected diabetes, undiscovered renal and liver ailments. Frequently we diagnose cardiac disease or prostate cancer before it is identified by the physician.

The question which I pose, is should the medical director be restricted to these endeavors, or are there other roles in a corporate setting that would bring benefit to the company and fulfillment to the physician? The first shibboleth that must be faced is the relationship of the medical director to the corporate staff, the senior management and the Board of Directors. On the one hand we are physicians whether we are in regular practice or not. On the other hand, most of us practice relatively infrequently and often not exclusively in our areas of expertise. More importantly we destroy the level playing field. In the assumption of a patient - physician relationship, we develop a special relationship. The corporate decision making apparatus simply does not allow for that relationship. One might contend that there are potential relationships that exist between other members of a decision making team, but their existence is not covered by the patient - physician confidentiality. The next shibboleth is the conflict that exists, for the medical director of a life insurance company, when they have patients for whom they are responsible, in anything other than an ambulatory clinic. As a business executive, the

demands of the company will often make a commitment to regular practice impossible, even if that is not the case, the perception is difficult to avoid.

Physicians make lousy business people! Another shibboleth that is patently not true for several Fortune 100 companies have or have had physicians as their CEOs. But these physicians neither see employees as patients, nor do they have practices on the side. For the physician in corporate management many activities are open including product design, marketing and sales, operational process, product development, investment and government affairs and professional liaison.

It goes beyond the scope of this article, to provide an exhaustive outline of the specific roles in which the physician can contribute in the above areas but some examples might suffice. For example, a life insurance company which wants to expand its line of business into the impaired risk annuity business would do well to have a physician in on the early planning stages. Superficially the current manual based rating system for impaired risk could be used, yet the philosophy is quite different. The product development team could use the technical expertise of the physician, in the design of the product, in the design of the application form and in the development of underwriting standards and requirements. This could also evolve into a sales and marketing situation, when the product is rolled out to the agency or brokerage sales force.

Physicians often carry a great deal of weight in their testimony to regulators and legislators, furthermore they are associated with powerful trade and professional organizations which are amongst Washington's greatest political contributors. And again, who can argue the point when it is put in terms of wellness, health, family and quality of life.

More strongly emphasized, in a life insurance company, a physician has legitimate interest in almost every facet of the business. Since the

success of the business is a function of the integration and smooth running of the different areas and departments, there could or should be a role, which is really a reflection of the chief executive officer. The CEO sets a vision, promulgates the corporate mission and induces the goals and objectives. There needs to be a linch-pin to synthesize and integrate information about all the different areas of the company. The role can also have a limited gate-keeper function which facilitates the responsibilities of the CEO in keeping focus on the core businesses.

It is often said that physician executives must retain some practice in order to retain credibility with the practicing physician. This, I do not believe, is accurate. While it is obviously inappropriate to be second guessing physician practice management if one does not have credibility in that particular field or discipline, a physician in management can often communicate more effectively with their professional equal in practice. The down side to maintaining a practice in the corporate environment is

that one patient can easily consume an inappropriate amount of time at an inopportune time and may provide a professional Achilles heel to disgruntled practicing physicians.

In summary, I believe that the role of the medical director in a life insurance company has a great deal of potential. There is a core business and discipline, insurance medicine, but for the ambitious corporate player, there are a wealth of opportunities providing one is prepared to make commitment and in some settings, sacrifices. These latter, may include additional training, relinquishing a practice, developing a team mentality and assuming the corporate culture of the organization.

### References

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