

The Evolving Insurance Paramedical Business

Clifton L. Reeder, M.D.
Vice President and Medical Director
American Service Bureau — Bodimetric Profiles
Des Plaines, IL

When Dr. Charles Pope started Medical Information Systems, circa 1967-8, the concept was to replace the physician exam with an expanded paramedical exam. Why? Physicians were increasingly in short supply. Most did not want to do insurance exams. They did not want the hassle of dealing with agents. They felt the fees paid for insurance exams were too low. Building a medical practice was almost as easy as hanging out a shingle. Many physicians felt that doing insurance exams was an insult to their professional dignity.

The paramedical, as originally conceived, consisted of the basic paramedical history and measurements, plus an electrocardiogram, a phonocardiogram, a timed vital capacity, blood chemistries and a complete urinalysis — all this became known as the expanded paramedical. The phonocardiogram was a device used in conjunction with the EKG machine. The thought was that murmurs could be identified and differentiation could be made between the organic and the functional. Unfortunately, interpretation of the waves was not always easy or accurate. So much confusion developed that this test was abandoned after 4-5 years.

The expanded paramedical was to be performed by a well trained nurse paramedic, in a fixed location, using salaried people exclusively.

The concept was excellent. The problem turned out to be the agents. They did not particularly like the fixed location. They certainly did not like the expanded paramedical. All that testing added considerable additional information to the underwriting process. Delays occurred to clear false positives. A higher percent of applications were rated or rejected — this was not appreciated by the agents.

The fixed location and salaried people were also a problem for the paramedical companies. Overhead costs were fixed but the volume of business was not. Profits did not readily accrue in the formative years.

When we started Bodimetrics in 1972, our concept was the basic paramedical on a mobile basis and nothing else. We were influenced in part by some insurance companies that had been analyzing and comparing the underwriting value of the basic paramedical and the physician exam. Their conclusion was that the basic paramedical produced almost as much information of underwriting value as the physician exam. After all, the essentials for underwriting are a good history and accurate build and blood pressure measurements. The few additional findings by a physician,

the heart murmurs and the rare lung diseases, were statistically not enough to offset the increased cost of the physician exam, and many times the underwriters were alerted to those possibilities by the history.

Why mobile? In the late 1940's and early 1950's, I did a lot of insurance exams to augment my salary. I remembered how appreciative the agents and the applicants were when I came to them. I also learned the hard way that when the agents made the appointment, I had many no-shows. When I made the appointment, I rarely had a no-show. Another factor entered into the considerations. Appreciably less investment in facilities would be required if we went mobile. After evaluating the pros and cons, it became obvious that mobile was the way to go.

In 1972, we thought our concept, the basic paramedical on a mobile basis, would never change. How wrong we were.

The electrocardiogram (EKG) is a very important underwriting tool. As the limits for the basic paramedical were raised, underwriters began to feel uneasy at the higher amounts without an EKG, especially above age 40. By 1974 or 1975, requests for us to add EKGs were so numerous that we felt we had to offer that service.

We began in Southern California with the machines available to us at that time. We quickly found that those machines were not meant to be portable. The breakdown rates and repair costs were high.

Then we discovered Phone-A-Gram. We tested that system in one location for several months before installing it throughout our offices. But by 1983, we were beginning to become disenchanted with Phone-A-Gram. Fees charged by Phone-A-Gram kept increasing each year, forcing us to increase fees to our customers. The Phone-A-Gram system used a special instrument to create the EKG. After hooking up all ten lead wires, an 800 number was dialed. When all was ready, the phone was placed in a cradle on the instrument, the start button was hit and in 45 seconds, the EKG was in the computer. The problem was that the computer had to print the tracing and then it had to be mailed to our producing office. Once we received it, we had to match it with the other information and forward it in accordance with customer requirements. Delays of 4-5 days were common. The agents did not like that delay.

In early 1984, we decided to investigate the possibility of conventional machines again. After much testing of several makes, we decided on one which we thought would be durable and produce excellent tracings. Phone-A-Gram was withdrawn and the new machines placed throughout our system. The electronic revolution has now permitted us to add newer lightweight machines which are automatic and produce excellent tracings when properly used.

Why "when properly used"? An EKG must be done exactly right. Any error can make the tracing useless. The limb lead wires must be on the right limbs. The chest lead wires must be in the right location and in the right sequence. The applicant must be comfortable and relaxed. Standardizations should be in every lead. Each lead should be properly marked. If the operator will stick to the basics, a good tracing will be made almost 100% of the time. Any deviation will produce a deficient tracing.

As the hazards of cigarette smoking became more clearly established, the next new service to be added was Timed Vital Capacity. When the test is properly done, it gives much valuable information about the lungs. Although it is no substitute for a Complete Pulmonary Function Study, it does give an accurate FEV-1 and FVC for a very reasonable cost. Unfortunately, many insurance companies use the test rarely, if at all.

In the late 1970's, with inflation on the rampage and interest rates skyrocketing, two things began to happen. Insurance companies began looking for ways to save operating expenses and financial officers began to demand ever more funds so that investments could be made with the then high yields.

Accordingly, non medical limits were increased dramatically, basic paramed limits were also increased, but the gain at the top did not offset the volume loss at the bottom. Paramed volume increased a bit as the number of applications increased, but the overall increase was small. And underwriting standards were relaxed. After all, those excess interest earnings could pay for a lot of mortality.

For ten years (1972-1982) we resisted the occasional request to draw blood. We were reluctant to offer that service because of the potential for liability when mistakes, or alleged mistakes occurred. Another consideration was the unknown quality and quantity of phlebotomists available to us. By 1982, we were receiving so many requests for blood draws that we felt we had to offer that service or possibly lose a significant amount of our basic business. We instituted tight controls over who could draw blood. To this day, those controls have never been relaxed.

Blood drawing started modestly in 1982 and increased slightly each year from 1983 through 1986. But in 1987 the increase was about 260% over 1986, and 1988 is well on its way to another 200% increase over 1987. Who knows where it will level off?

Although AIDS was first diagnosed in 1982, its potential impact on the insurance industry was not immediately recognized. When the impact finally hit home, dramatic changes began to take place in the insurance business as well as the paramedical business. Non-medical and paramedical limits were lowered, not raised as in the past; blood drawing began accelerating; underwriting standards were tightened and underwriters began underwriting for risk, not volume.

Insurance companies began taking a hard look at their paramedical vendors. We never did know how many were out there, but some insurance companies were using 50 to 100, or even 200 vendors. Doing business with that many vendors did not permit any control over quality, price or billing. It began to be generally recognized that fewer vendors could mean better control over quality and price. That trend has accelerated in recent years and I suspect it will continue until there are 3-4 national companies and another 2-5 regional vendors. Keeping the numbers small still permits competition, but keeps the pressure on the vendor to maintain quality and to hold the line on price.

The quality of our services has always been of paramount importance to us. In the beginning, we audited every paramed we produced. As the volume increased, so did the costs. We then went to a system of auditing by regional field representatives. Again, the costs increased until we had to find an alternative. Spot checking and random auditing were installed, but were not as effective as we had hoped.

Many years ago, we began thinking of a computer quality control program. No problem, except for the histories. Since the coding had to be done in the field, we had to develop a simple way to code, one that would be understood by all. One where compliance would be almost 100%. Counting the number of words on the Part 2, was one method which we explored and abandoned. Finally, we hit upon the number of illnesses reported on the Part 2. "0" was no history. "1" was one illness or a check up or physical exam. "2" was two illnesses. "3" was three or more illnesses. Since colds, sore throats, flu, herniorrhaphies or appendectomies do not influence underwriting, our instructions are not to count them at all. Our program is now in place. It permits us to monitor each office, each representative and each customer. An office may produce average, above average, even excellent work and still have one or two representatives producing poor quality. A system must be able to identify such representatives so they can be retrained or terminated. Over the years, we have discovered that if our representatives perform as trained, and do not deviate from that training, we have few problems. It is the representative who decides that his way is better, or that a shortcut really doesn't hurt quality, that produces trouble. Our quality control system will identify that representative, thereby enabling us to take corrective action.

What does the future look like? Bright, both for our customers and the paramedical business. Although the paramedical business is a mature business, it is not a static

business. Change has been part of the scene since the first experiment began over 20 years ago.

At the moment, it is difficult to imagine what new services will be added in the future. Electronic transmission of information is already here. Direct entry into the underwriting computer will probably be next.

We have already added a core of physician examiners to perform MD examinations when needed. American Service Bureau proved the value of the Personal Statement in replacing inspection reports, many years ago. Why so little use is made of this service is puzzling. In today's world, the applicant is by far the best source of information. Lifestyle, habits, avocations and finances are definitely known by the applicant. And reported truthfully, almost always.

We have been given estimates that five times as many blood specimens will be drawn in 1990 or 1991 than will be drawn in 1988. That is a lot of blood draws. Will we, the para-

medical industry, be able to handle that volume? In all probability, yes. Obviously, we will need a lot more phlebotomists. We shall probably have to train them ourselves. The volume of blood drawing may force a specialty in that service alone. The introduction of the finger stick and filter paper system may ease our phlebotomist problems. However, I suspect many insurance companies will go slow with this system until it is absolutely proven that it gives comparable results.

Whatever happens, the future will not be dull.

Although this paper is based on the experience of Bodimetric Profiles, I suspect our competitors have been through much the same process, with obvious exceptions here, there and yonder. I feel confident that the paramedical industry will continue to serve the insurance industry with quality products. Although each paramedical company is structured differently, our goals are the same. Let's keep them that way.