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HEALTH E-SCAN BECOMES PART OF HANK GEORGE, INC

The industry's only newsletter devoted solely to health insurance risk management (which you happen to be reading) has moved from Risk Concepts LLC to Hank George, Inc.

My sincerest thanks to my colleagues at Risk Concepts, LLC – Ben Chaput, Mike Steinhardt, Erik Thomas and Kathy Thomas – whose help with the launch of this publication was invaluable.

We shall carry on so that Health e-Scan will fulfill its mission: to provide information, insight and opinion on issues affecting health underwriting.

Hank George, FALU, CLU, FLMI

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THE SPECTER OF GENETIC TESTS ORDERED BY THE PATIENT

"Go online today, and you can order tests–without visiting a physician–to determine your genetic risk for cystic fibrosis, thrombophilia, breast and ovarian cancer, among others."

Kay Downer
"Direct-to-Consumer Genetic Testing
It's Here, Ready or Not"
Clinical Laboratory News
31,6(June 2005):1

DTC (direct-to-consumer) genetic tests are now marketed by a number of firms in the USA and Canada. They are legal and they have attracted considerable interest among persons who are concerned about being at risk.

Why would a patient choose this option and pay 100% of the bill?

Because it assures the absolute confidentiality of the results…a reality awash with implications for life and health insurance risk.

We need to make a distinction between testing for monogenic versus polygenetic diseases. Monogenetic impairments, like cystic fibrosis and Huntington Chorea, are (thankfully) rare and thus unlikely have a tangible impact on morbidity (or, for that matter, on mortality).

The same is not true of polygenetic diseases, which include hypertension, diabetes and most forms of prevalent cancer.

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When we say these diseases are polygenetic, this is not the same as saying that their origins lie solely with inherited genetic factors. Indeed, what people do in their lives – acquired behaviors and practices – have every bit as much (and, in most cases, much more) to do with their risk of commonly-encountered impairments than do strictly inherited gene mutations.

Those firmly opposed to DTC genetic test direct marketing argue that "…consumers lack the medical knowledge and understanding of genetics required to make informed decisions about these tests."

Just so.

Proponents of these tests insist that there is enough information at websites and elsewhere to empower consumers to understand their test results.

You think? Me either.

Without question, speaking from a wellness/longevity perspective, *anyone who sought out these tests would be well-served to share the results with their physician…*

…but, if they do, those results would likely become a part of their medical record (at which point they would have paid out of pocket and *still be at risk for disclosure of test results to employers and insurers).*

The time to expand our knowledge of genetic testing is at hand.

The need for resolving issues brought forth by the explosion of genetic research and the growing array of genetic tests is also at hand.

In the meantime, *Health e-Scan* will report on new developments related to genetic testing that may have relevance for our profession.

Chiropractic

Interesting exchange of letters to the editor of the *Archives of Internal Medicine* [165(June 13, 2005):1313] on the impact of open access to chiropractic care on health care outlays for neuromuscular conditions.

The first letter, responding to a prior paper, raises many points, one of which asks "is chiropractic care beneficial?" The letter writer holds that there is scant solid evidence as most studies done in the accepted manner are flawed.

Then, he relates anecdotes about tragedies where patients with treatable life-threatening diseases waited too long before seeing an MD because they were being treated by chiropractic for symptoms of the disease that ultimately proved fatal.

The response…as always, coming from the author of the original paper [Logorreta. *Archives of Internal Medicine*. 164(2004):1985-92]…counters, saying that studies have demonstrated that, in its proper domain, "…spinal manipulation [is] as effective as competing therapies [meaning those used by MDs and others, of course]."

He also makes the point that while any form of alternative medicine must be held to standards of scientific scrutiny, the fact remains that a handful of anecdotal cases do not change reality (here or anywhere else).

For what it is worth, this underwriter agrees wholeheartedly with the second physician. Chiropractic has established itself as a viable form of therapy, as have other forms of alternative and complementary medicine…ABOUT WHICH MOST UNDERWRITERS KNOW DISCOURAGING LITTLE.

If anything needs to change in our industry, it is the sobering validity of the capitalized message. What underwriters do not know has a much more robust impact on insurers' bottom lines than what they inadvertently overlook!

Nondisclosure

> I distinguish two domains of nondisclosure: incidental and overt (i.e. antiselection).

To say that nondisclosure is relevant to us is like saying… well, you know!

Indeed, it is a perpetual topic of discussion at the annual BUGS [better underwriting = greater sales] seminar that my UK friends and I do in London.

And it is soberly relevant to them as they are, proportionally speaking, well ahead of us in the embrace of teleunderwriting.

Reflecting on this, I distinguish two domains of nondisclosure: incidental and overt (i.e. antiselection). What is intriguing is that the former is likely many times more prevalent than the latter…and moreover that the mechanisms that catalyze this are not only within our grasp but also often, for want of a better way of saying it, our own fault.

This is one of the topics that this underwriter will discuss at the forthcoming first (annual?...we hope so, if we get a solid response!) Society of Actuaries Critical Issues in Health Underwriting seminar on September 19 and the morning of September 20 at the famous Palmer House hotel in downtown Chicago.

An esteemed team of presenters will delve into a wide range of contemporary issues related to health insurance risk management. That team includes, among others well known to all of you, Karen Pollitz, MPP (who spoke at the 2005 HUSG meeting) and Mila Kofman, JD, who are both on the faculty of Georgetown University's Health Policy Institute.

If there ever was a MUST ATTEND event in health underwriting – and the sad fact is that such events have not been as numerous as they should be – this is it!

To find out more, please visit www.soa.org and click on Meeting/Seminars and Continuing Education Programs.

Or, give me your address and I will see to it that you get the brochure!

By the way, what is the only PROVEN antidote for incidental

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antiselection (and sometimes the OTHER kind, too)?

Teleunderwriting! This is the only way open to us to minimize incidental and overt nondisclosure.

Rx In Chronic Non-cancer Pain

Chronic pain is held to affect 86,000,000 Americans, with profound implications affecting their daily lives.

The tab?

$90,000,000,000 for medical expenses and reduced productivity.

Maizels and McCarberg [*American Family Physician*. 71,3(February 1, 2005):482] have written an excellent review of this subject. They point to the distinctions between nociceptive (from injury or inflammation of somatic or visceral tissue) and neuropathic (from neuronally-mediated pain maintenance in either the peripheral or central nervous systems) chronic pain.

The former is managed by anti-inflammatory or analgesic meds. The latter, on the other hand, requires drugs influencing neurotransmitter actions, with only the most severe neuropathic pain being managed with opiates and opioids.

Certain anticonvulsant and antidepressant meds are particularly efficacious in managing neuropathic pain…even though their "indications" may not clearly reflect this.

Among the antiseizure drugs, gabapentin (Neurotin®) leads the way. It is already approved for post-herpetic neuralgia but is equally effective in other forms of this genre of pain. When dispensed for this use, the doses (2,400 to 3,600 mg/day) are usually higher than in many patients receiving the drug for seizures or bipolar disorder.

In the antidepressant Rx family, both tricyclics and those agents that have combined activity on both serotonin reuptake – venlafaxine [Effexor®] and the new one known as duloxetine [Cymbalta®] – are particularly notable in this capacity.

How does this impact underwriters?

The logical inference when we see these drugs is that they are being given for their established indications. In the case

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of the antidepressants, one's first instinct is to presume that the underlying condition is an (undisclosed?) affective disorder.

Nevertheless, it may be chronic pain, an insidious impairment with major implications for morbidity risk.

Best advice?

Resist premature conclusions.

Look at the whole risk.

The decision you render could very well understate (or vice versa) the true degree of risk.

Speaking Of Rx

Because the assessment of health insurance risks is so deeply enmeshed with an understanding of clinical pharmacology, we will try to have a segment on Rx in every issue of *Health e-Scan.* This time, let's look at a few important tidbits in this domain:

- A recent study in the *British Medical Journal* [330(March 5, 2005):503] reports on 251 adult outpatients with a first or recurrent episode of major depressive disorder, free of any psychotic manifestations. They were randomized to receive either the SSRI paroxetine [Paxil®] or the oft-maligned herbal remedy St. John's wort.

What do you suppose happened?

Those who received St. John's wort derived AT LEAST as much benefit as those taking the established antidepressant.

You do ask about use of alternative and complementary medicine, right?

And you do know how to adequately evaluate what you are told?

Both answers better be YES, considering that alternative remedies are growing at a much faster pace than conventional Rx, especially in more educated and affluent elements of the population…and in those with relatively higher degrees of risk.

- Folates [a B vitamin] are widely prescribed by physicians, not to mention used over-the-counter. When we see a reference to this in a medical report or teleinterview drilldown, we need to pay close attention as to why folate supplementation is being taken.

What if I told you that:

…there are no less than 5 studies showing that *folates both enhance the efficacy of antidepressants and expedite recovery from depressive episodes?*

…folate supplementation is indicated in hyperhomocysteinemia, a widely-accepted risk factor for accelerated

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atherosclerosis.

…folates are also used with methotrexate – the #1 rheumatoid arthritis drug also used in severe psoriasis and cancer, among other things?

- We all know by now about the issues surrounding the safety of the coxibs used to treat rheumatoid arthritis, osteoarthritis and pain. Two have been pulled off the market and there is widespread concern for the cardiac risk implications of lone survivor, celecoxib [Celebrex®].

Well, there's another coxib looming.

Lumiracoxib.

It is approved in Europe for RA, OA and gouty arthritis, and their research, as capsulized by Solomon in *Arthritis and Rheumatism* [62,7(July, 2005):1968], shows no evidence of the CV risk that has stigmatized the others.

- Milk thistle (silymarin) is an herb. It is widely used to "treat" persons who have chronic liver diseases. Among the 10-15% (or more) of such patients who indulge, most base their decision on advice from friends, Internet information and the like. Indeed, they usually do not reveal their use of this herb to their attending physician.

Now it looks like the liver experts are going to move forward to further assess the efficacy of milk thistle, which may culminate in its wider use.

Just thought you'd like to know this, considering that most underwriters would blow right past the mention of this herb, unaware of the potential implications.

TREATED DISEASE PREVALENCE

An outstanding – must read – paper on this subject was published by Health Affairs as a "Web exclusive." It was written by Thorpe and three coworkers from Emory University in Atlanta.

They assessed the rise in treated disease in selected conditions between 1987 and 2002.

The top five in terms of "cost per treated case:"

1. Cerebrovascular disorders
2. Kidney problems
3. Cancer
4. Newborn and Maternity Care
5. Heart disease

The top five in terms of "percentage change in spending due to change in treated prevalence:"

1. Cerebrovascular disorders
2. Back problems
3. Mental disorders
4. Upper GI disorders
5. Heart Disease

"…treated disease prevalence has increased in response to changes in clinical treatment guidelines and standards for treating asymptomatic and mildly symptomatic cases."

As in, subthreshold case of depression, panic disorder, bipolar disease, etc.

The questions we have to ask ourselves as underwriting managers?

Are we as good at underwriting TIAs and chest pain as we are at bum knees?

Would our underwriters even recognize a subthreshold psychiatric risk?

If we don't here many "NOs," there are some growing noses amongst our readers!

GERD IN OLMSTEAD COUNTY, MINNESOTA

Olmstead County, home of the Mayo Clinic, is an upscale area probably demographically similar to many insurance markets. So when researchers from that esteemed institution assess the prevalence and implications of any medical impairment in their community, it IS news for us all.

Nandurkar et al. [*American Journal of Gastroenterology*. 100(2005):1459] found 242 of 2118 Olmstead County residents who'd acknowledged frequent gastroesophageal reflux (as in the GER of GERD…the D being disease).

Of this cohort, 54% sought medical attention. Only 33% were taking Rx for GERD – mostly antacids (24%), histamine receptor blockers (23%) or proton pump inhibitors (4%).

Why so few PPIs?

Consider that these patients were first identified in 1993 and their records followed to 1998. PPIs have ascended to the peak of the GERD Rx pyramid over that interval and most OTC choices by patients will be either antacids or a histamine receptor blocker.

Barely more than 10% of these subjects actually saw a GI specialist. Overall, 19% had esophag-(or beyond)-oscopy. Four had a Barrett esophagus; one of these had adenocarcinoma of the esophagus. Three had surgery for reflux (fundoplication).

How often is a potentially-premalignant "Barrett" discovered in a population with severe GERD symptoms?

Just a bit less than 10% of the time, actually…which means a considerable watershed frequency of further assessments if the patient is compliant.

Ok, which factors predicted for endoscopy being preformed?

After multivariate analysis:

1. Severe acid regurgitation
2. Professional training or college degree

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BARRETT ESOPHAGUS, A POTENTIALLY PRE-MALIGNANT METAPLASTIC LESION, OCCURS MOST OFTEN IN THE CONTEXT OF CHRONIC GERD.

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3. Severe heartburn
4. Sought out care specifically for GERD symptoms
5. Acid regurgitation once a week or more often

Are we in for an "Epidemic" of PTSD?

PTSD, of course, is posttraumatic stress disorder, a particularly tenacious anxiety impairment with a virtual "phone book" of comorbidities.

The word "epidemic" might be a tad strong…but, then, considering that two Israeli investigators [Shalev and Freedman. *American Journal of Psychiatry*. 162(2005):1188] found a 36.8% prevalence of this condition in one setting, maybe "epidemic" is indeed on the radar screen.

That population?

Those who survived terrorist attacks.

They were twice as likely to develop PTSD as survivors of car crashes.

And the prevalence of depression in the *terrorist attack* cohort was also much higher.

It has recently been said that soldiers returning from the war in Iraq are at high risk for PTSD as well. Many of them are reservists who will return to civilian occupations where they will have…or seek…health insurance.

Enough said.

Wastage

At the recent AHIP conference in Las Vegas, the point was made that we are at a time in our industry where it is imperative to focus on minimizing wastage…which we shall define for our purposes here as *NOT* ISSUING coverage to *INSURABLE* RISKS.

If this is so – and people more expert than I maintain it is – then we need to prioritize for ways to decrease the incidence of avoidable wastage.

As in chucking out bad or obsolete underwriting guidelines

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that miss the forest for the trees…because you cannot be at the top of your game if you don't have the very latest and most accurate information, at least on the most prevalent impairments presented for consideration.

Which means what?

- Better underwriting manuals
- Superior underwriting practices
- Ongoing underwriter access to *top shelf* continuing education
- Careful audits, including assessment of the quality of critically-important services (i.e. outsourced teleinterviews)

Want another reason to embrace these priorities?

Sarbanes-Oxley.

More on this in Chicago in September for those who see the wisdom of being with us for a powerful day and a half of learning and dialogue.

Hope your summer is joyous…and not as hot as mine has been here in *suddenly-tropical* Milwaukee!

Hank

The most comprehensive laboratory test underwriting guidelines ever written for health underwriting are now available to all health insurers, from Risk Concepts, LLC.

Call Mike Steinhardt at 262.347.2249, or e-mail him at jmsteinhardt@riskconcepts.net for a free look.

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