

# Hank's Health e-Scan

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## A Word from Hank

Effective this issue, Hank's Health e-Scan will now be distributed to all HUSG members on a complimentary basis, courtesy of Risk Concepts, LLC.

We decided that the mission of this publication is to get important information to health/medical insurance underwriters and that this mission could not be accomplished if we placed a financial barrier between those who want to read it but cannot get the outlay for a subscription approved (a sad commentary on the choices made by many carriers!)

Those who did subscribe will get a full refund.

And from now on, six times a year, you will get Hank's Health e-Scan.

We hope you like it.

## HOWARD BOLNICK HITS A HOMER

Professor Howard J. Bolnick, FSA, wrote a provocative essay titled "A Shock to the System" for the January/February, 2005 issue of CONTINGENCIES, a publication of the American Academy of Actuaries in Washington, DC. This underwriter has had the privilege of writing for this bimonthly a number of times, knowing as he did so that it circulates to a very large and influential insurance industry readership.

Therefore, count on what Howard said in his superb essay to be widely read. Good...because maybe the net effect will be to shake us out of our complacency!

Howard's main theme is that we need to get serious about *innovative* risk management strategies that "...balance adequate risk classification with public concerns..." and you know what those concerns are: negative perceptions of how we underwrite that are said to account, in part, for health coverage being unaffordable/unavailable to so many potential customers.

Howard asks if we are keeping our practices on the cutting edge, honing in on a key issue: do we overdo much of our debiting (or worse) of those taking antihypertensive, hypolipidemic and psychotropic Rx?

The use of all 3 of these classes of drugs has literally exploded in the last decade. Many who are medically managed with these drugs have mild degrees of impairment, in some cases...

...[for example, where internists are treating prehypertension [BP < 140 and < 90] or where short courses of psych Rx are used situationally... with no significant impairment at all.

Moreover, the effects of adjuvant therapies stressing lifestyle and behavior modifications in all three of these scenarios act to reduce morbidity risk independent of the direct beneficial effects of the drugs. This has been demonstrated

repeatedly in epidemiologic studies. Do we fail to see the forest for the trees when we exaggerate the morbidity based on the (often-overstated...to get the bills paid?) diagnosis and then further miss the fact that other interventions reduce the net adverse impact on our bottom lines?

It is no secret that treatment with statin cholesterol-lowering drugs is expected to skyrocket from the present 12-13 million users to 3 times that number in 5 years. Many will be receiving statins in situations where their lipid profiles are barely borderline abnormal by prevailing criteria. Much of the incentive to treat them will be linked to benefits of statins, and other drugs, that transcend their primary indications. In other words, those who receive and take these drugs will not only enjoy favorable reductions in borderline lipids but also a range of other benefits that will substantially cut their risk of acute circulatory events.

This needs to be reflected in how we underwrite.

How do we deal with the fact that 40 million Americans may be candidates for serotonin reuptake inhibitors (Prozac, Zoloft, Paxil, etc.) despite, in many cases, having little in the way of true psychiatric morbidity?

In research I did for a paper on Prozac uses for a lecture at the annual Canadian Institute of Underwriters in 1995, I found **over 40 off-label uses** for this drug, many of which had little or no important morbidity. That list might twice as long a decade later!

**The fact that one has been given an SSRI does not, by itself, assure significant morbidity.**

There are positive steps we can take to upgrade our underwriting so that we are in tune with modern medical realities:

1. Upgrade underwriting guidelines. Isn't it time we get beyond scotch-tapping notes to ancient manuals from long-departed health reinsurers or trying to adapt life underwriting guidelines to accommodate our needs? The impact of our underwriting starts with the quality of our guidelines.

2. Upgrade the Rx knowledge of our underwriters. Our grasp of the relationship between Rx prescribing and underwriting is inadequate to handle the realities of 2005. Over 30% of the drugs prescribed in the US this year will be prescribed "off label." If we do not have insights into off-label Rx use, we will miss the boat in case after case, over- (or sometimes under-) reacting to the situation because we try to fit a round peg into a square hole. At the end of the day, more good business will be lost than bad business written.

3. Provide continuing education for our underwriters. In the complex domain of medicine, one can become "obsolete" in a year's time relative to new science that changes what we always believed. Underwriters who don't stay current transform into liabilities. Companies have an obligation to their underwriters – and to themselves – to provide quality CE. How many really do so?

4. Come to better understand adjuvant therapies related to health habits and lifestyle, and what they mean in terms of risk. The totality of treatment, not just the pharmacological aspects, must be considered. If someone participates in secondary prevention strategies, whether traditional or based on alternative and complementary medicine (a vast domain about which underwriters know next to nothing and have no guidelines whatsoever), this has almost as great a bearing on insurability as the medical history itself.

5. Make use of teleunderwriting as the primary means of risk information acquisition. The only way

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we are going to be able to underwrite the applicant as a whole risk is to have insights into that individual which transcend conventional strategies like non-medicals and para-medicals. Medical histories taken in these traditional ways have a fraction of the value of those we can now get from top-notch teleinterviews. It is no exaggeration to say that health insurers who are NOT teleunderwriting in the next few years will be at a very serious competitive disadvantage in terms of making the best risk decisions and minimizing wastage.

Teleunderwriting is not back-burner any longer.

Maybe an example will suffice. At one of my life study groups two weeks ago, an underwriting Vp reported doing random teleinterviews of a batch on nonmedically-submitted business where all the medical histories were "clean." 30% had personal physicians that had not been acknowledged. 10% had medical histories that required adverse action...AND THIS IS FOR LIFE INSURANCE, NOT HEALTH INSURANCE!

The path to maximizing the benefits of 21st century risk management is no longer experimental or hazardous. Just the opposite because that path to now has clearly-defined benchmarks, based on trails blazed by innovative industry leaders.

## SCINTIMAMMOGRAPHY

The use of radioisotopes has come to the mammogram, in the form of [ 9 9 m T c ] - s e s t a m i b i scintimammography. A recent study by University of Washington radiologists and oncologists has shown that this novel form of breast tissue radiography accurately predicts the response of breast carcinoma patients to post-surgical chemotherapy.

As every underwriter knows, the use of both radiation and chemotherapy, following lumpectomy and mastectomy, has increased enormously. This is because these so-called "adjuvant" interventions have reduced the risk of disease recurrence.

It is often difficult to determine, from the nature and extent of breast cancer treatment, if one is dealing with a BEST CASE scenario as

opposed to one fraught with long-term excessive morbidity. This new radio-imaging mammographic technique, recommended here for "locally advanced" disease, will serve as a red flag for cases that should be expected to have significantly higher morbidity, for a longer interval, than we would see in those who have very small lesions.

Dunnwald. CANCER. 103,4 (February 15, 2005):680

## CHRONIC FATIGUE SYNDROME GAINING "DISEASE" STATUS

In the February 5, 2005 BRITISH MEDICAL JOURNAL, a brief report acknowledged that chronic fatigue syndrome (CFS) has now been recognized as "...a genuine, severely-incapacitating disorder" by the Netherlands' Health Council. No doubt this is a harbinger of things to come as experts in the field get closer and closer to defining the parameters of this ill-defined condition.

Some experts maintain that CFS has several different causes rather than a single unifying unknown pathogenesis. Certainly a significant share of cases present as a seemingly-viral illness, while many

others take on the characteristics of an atypical psychiatric impairment.

One thing underwriters need to know about CFS is that it is closely associated with several other well-known – and highly chronic – impairments. Indeed, one might refer to them collectively as "the functional syndromes" for now, pending further insight into their causes.

These impairments include fibromyalgia, irritable bowel syndrome, generalized non-ulcer dyspepsia and temporomandibular joint disease (TMJ). Studies in recent years have shown considerable overlap between these conditions,

with the prevalence of CSF higher in those with any of the others than in the general population, and so on.

Where there is smoke, there is fire, where these conditions are concerned. Where one is diagnosed or strongly suggested after excluding other causes of the symptoms at hand, the underwriter MUST be alert to signs and symptoms of the others. With the exception of TMJ, riders are of little efficacy here and the potential for morbidity is broad.

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## ALTERNATIVE & COMPLEMENTARY MEDICINE ON THE MARCH

In the September 6, 2004 issue of THE JOURNAL OF ALTERNATIVE AND COMPLEMENTARY MEDICINE, Watts and two coworkers reported on "The Effect of Mandating Complementary and Alternative Medicine Service..."

Here are some of the punch lines regarding the growth of A&C therapies in our society:

- We had less than 50,000 chiropractors in 1990. We will have just under twice that number by the end of this year
- The number of licensed acupuncturists will have quadrupled over the same interval, reaching an estimated 21,000 this year
- Between now and 2010, the number of conventional MDs is expected to rise 16%, whereas the number of CAM practitioners will jump up 88%
- Nearly 50% of Americans use some type of CAM and many use several, or more

- Two naturopathic physicians (N.D.s) were named to a major national health advisory board, a distinct and telltale departure from the recent past.

If these numbers don't grab your attention, then try three more facts that could have profound ramifications for underwriting:

1.A&C use is proportional to income. The likelihood of smoking decreases as income and social standing go up. Ditto for HIV. Not so for CAM. The more they make, the longer they went to school, the more CAM they use!

2.The use of CAM is inverse to life expectancy with chronic disease. The sickest people use it the most.

3.Over 50% of patients on CAM do not disclose their practices to their own physician, so you won't be seeing much about this on the APS (unless the doctor disapproves of what his patient is doing and tells him so!)

Health insurers can count on the heat being turned up a notch or two

each year where covering major A&C interventions are concerned.

Underwriters can count on mentions of A&C use by applicants who would never tell their judgmental personal physician. Where will these mentions be? On teleinterviews, as the Mayo Clinic amply demonstrated in a published study.

The risk implications of some forms of CAM are prodigious for health insurance.

For example, would you be concerned about a 55 year old female taking hawthorn (an herb)?

You should be.

Hawthorn is widely recognized, even by conventional MDs, as an effective intervention for early congestive heart failure.

We need to get serious about CAM or we will pay dearly for what we don't know.

## BICUSPID AORTIC VALVE – THE LATEST INSIGHTS MATTER!

We always thought that when one was born with a compromised (2 valve cusps instead of the usual 3) aortic valve between the left ventricle and aorta, one was the unlucky victim of a congenital birth defect.

Now we know the truth...BAV is genetically-transmitted.

In a review of heart disease issues in THE JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY, Rahimtoola etal [45,1,(January 4, 2005):111] tell us that the prevalence of BAV is much greater than one believed. In the relatives of 309 subjects with this lesion, 24% had a BAV and 31% overall had either BAV

or another cardiovascular malformation.

We know that BAV is subject to premature calcification, which may act to gradually compromise its function and culminate in aortic valve regurgitation (insufficiency) and later valve stenosis as well. There is evidence now that the incidence of subclinical (without symptoms or even an audible murmur) aortic valve damage is greater than once thought in those with BAV.

Basso and her coworkers in Padua, Italy [The American Journal of Cardiology. 93(2004):661] evaluated 817 healthy 10 year olds. They found that 0.75% of the males and 0.24%

of the females had a BAV based on transthoracic echocardiograms. Needless to say, extrapolated to the general population, we see BAV cases every month.

The questions are:

(A) Do we know it?

(B) If we do, what is the magnitude of the risk?

The latter answer could be unpleasant, given the high % of BAV patients who eventually need a valve replacement due to slowly worsening valve function, with regurgitation then stenosis, manifesting over several decades.

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## ALCOHOL – THE INSIDIOUS PERPETRATOR OF MORBIDITY (THAT ALL TOO OFTEN GOES UNIDENTIFIED!)

According to the ever-revealing MORTALITY AND MORBIDITY WEEKLY REPORTS [53(2004):866] – known to doctors simply as MMWR and published by the CDC - the impact of excessive drinking is huge...and largely off the health underwriter's radar screen!

If alcohol-related events are the 3rd leading cause of death in America, imagine what toll they must extract in morbidity terms.

No fewer than 54% of alcohol-linked deaths were due to acute conditions, not chronic disease. This is why some of the ER reports may have higher yields than most underwriters appreciate, especially considering that the #1 cause of trauma-related alcohol morbidity occurs in the form of drunk driving.

It is staggering to know that alcohol produces 50% of the morbidity associated with smoking...and smoking is the #1 preventable cause of excess morbidity in our society.

What can we do about these realities in health insurance?

Start learning the insidious signs of heavy drinking when they appear on medical records, lab tests and during teleinterviews.

Where lab tests are concerned, did you know that the mean corpuscular volume red blood cell index, done on every CBC, has higher specificity for

heavy drinking than an elevated GGT?

How many raised MCVs float under our radar undetected, in part because clinical MDs are forever failing to make the link between macrocytosis (high MCV) and alcohol in their own patient analyses?

Insurance laboratories offer us two valuable markers for heavy drinking that are rarely used in health underwriting: CDT (carbohydrate deficient transferrin) and HAA (hemoglobin-associated acetaldehyde). These tests are widely used – and commonly misused as well – by life underwriters. They can be done on any blood specimen and labs hold these specimens for at least four weeks if one must go back and belatedly ask for the test to be run.

What advantage to CDT and HAA confer?

Superb specificity, which is why they are the perfect asset when we have clues but not enough solid evidence to make a final decision. The best example of this is an isolated GGT elevation on a screening blood profile.

When Kathy, Ben and I asked health risk managers what is the #1 area where their underwriters were most in need of accurate, current information when it comes to sorting risks, they told us: LAB TESTING.

So we did something about it. The brand new RISK CONCEPTS LAB UNDERWRITING MANUAL© based on the complete redoing of the LAB TEST section of the RISK CONCEPTS INDIVIDUAL MEDICAL UNDERWRITING MANUAL.

This section, as a stand alone manual for all health insurers who select risks individually, will be available soon on a CD.

What makes this manual worth shouting about?

The fact that no set of lab underwriting guidelines in all of mortality and morbidity underwriting is as current and comprehensive as this unique document. Everything is there, including the alcohol markers, the newest cardiac markers, PSA, all major CBC components and every test on the screening blood profile.

If you don't have access to credible and complete lab testing guidelines for health case underwriting, you will shortly.

For more information, please contact Kathy at [kthomas@execpc.com](mailto:kthomas@execpc.com) or 262-695-8657 for this comprehensive resource that recommends an underwriting action in every lab-related underwriting scenario you are likely to see, backed up by access to this underwriter with any questions you may encounter - as an owner of this new manual- in lab test analysis on your toughest cases!

## HUMAN PAPILLOMAVIRUS (HPV) VACCINE

There are hundreds of varieties of HPV. A small percentage of them are potential female cervix carcinogens, and two in particular, HPV 16 and HPV 18, are implicated in the large majority of precancerous and invasive cervical carcinomas.

Now, Goldie et al have shown that a vaccine for these two troublesome HPVs can be used to combat their impact on women of all ages.

This vaccine has been found to be 100% effective in preventing persistent HPV 16 infection, as well as the intraepithelial dysplastic lesions that are induced by this virus. These authors, in their paper in THE JOURNAL OF THE NATIONAL CANCER INSTITUTE [96,8 (2004):604], believe that teaming up vaccination as primary prevention and cervical cytology screening as secondary prevention will have a dramatic impact on the incidence of cervical cancer in the years ahead.

When will the vaccine be commercially available? The authors say this could happen in just a few more years.

No doubt this vaccine, along with high quality HPV testing, will change the face of cervical cancer screening as dramatically as the introduction of the PAP smear made such screening feasible for the first time.

