Volume 2, Number 2 April 2006

Hank's Health eScan

2005 Society of Actuaries Health Underwriting Seminar

September 20 and 21, 2006... at the BIG Marriott in beautiful downtown Cleveland (adjacent to a wonderful mall and not far from Jacob's Field).

Stay tuned for details on the speakers and program.

And this time a SPACIOUS room...we promise!

April 06: Articles

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Parity in Mental Illness Healthcare Coverage

Goldman et al. (*The New England Journal of Medicine*.35 4,13(2006):1378) compared seven employee health benefit programs that embraced mental health benefits with a matched set of plans that did not do so. They observed that the main obstacle to achieving appropriate coverage in this regard was the perception that such benefits would lead to "large increases in the use of mental health..." services.

Their study showed that this assumption was incorrect, concluding that "...parity of coverage of mental health and substance-abuse services, when coupled with management of care, is feasible and can be accomplish its objectives of greater fairness and improved insurance protection without adverse consequences for health care costs"

An editorial in the same issue by Glied and Cuellar supported these conclusions, arguing that prevailing resistance to such progress is rooted in the misperception that psychiatric care remains anchored in long term psychotherapy, when, in fact, today's approach is a combination of time-limited counseling plus medication.

From our perspective, this editorial also issues a warning: find a way to get those done now or anticipate legislative interventions toward this end.

Projected Prevalance of Arthritis From 2005 to 2030

Hootman and Helmick (*Arthritis & Rheumatism*. 54, [2006]:226) used the 2003 National Health Interview Survey to project the prevalence of arthritis into the intermediate future. What they found was that self-reported, doctor-diagnosed cases would increase 23% in the adult population, reaching nearly 68 million in the next 25 years.

By 2030, some 25 million of us will have arthritis-mediated activity limitations. Moreover, adults still in the workforce will account for one case in three of clinically-evident arthritis.

The authors maintain that these numbers suggest a considerable impact on the health care system. One might add that they also mandate improvement – right now – in our ability to underwrite the impairments associated with these outcomes.

Anti-infarction Prophylaxis

A new paper by McMurray et al. (*Journal of the American College of Cardiology*. 47,4(2006):726) has shown that not only are angiotensin receptor blockers (the “-sartans”) as good as the angiotensin converting enzyme (ACE) inhibitors (the “prils”), but the two of them together “may have a small additional anti-infarction effect...”...a prospect they believe worthy of further study.

Let’s see now...a statin, an ARB and an ACE inhibitor...for high risk (how about moderate risk?) patients...think the annual cost of prophylaxis is destined to outpace the annual cost of MIs?

Which Hospitalizations Cost the Most?

Feldman and 13 coworkers (*Journal of the American College of Cardiology*. 46,12(2005):2222) assessed hospital admission costs for a range of interventions. Among those they considered, the **five most costly** were:

- Heart transplantation
- Cardiac valve replacement or other major cardiothoracic surgery
- Cardiac defibrillator implantation
- Cardiac pacemaker implantation
- Circulatory disorders with acute myocardial infarction and other major complications, discharged alive (dead was cheaper!)

In contrast, the reasons for **far less costly** admissions included:

- Chest pain
- Stable angina
- Deep vein thrombophlebitis (not made much more costly with pulmonary embolism)
- Transient ischemic attack
- Syncopal episode, with or without complications

This should be instructive to us when measuring the relative risk implications of what we learn on teleinterviews and MD reports.

PREDICTING BACK PAIN

Researchers from the Ontario Child Health Study (*American Journal of Epidemiology*. 162,8(2005):779) looked at risk factors associated with subsequent back pain in young adults. These are the ones they found to be significant:

- Any level of psychological distress (with essentially no difference between mild vs. severe levels)
- Current heavy smoking
- Low levels of parental education in childhood
- Emotional or behavioral disorders in childhood

This shows us clearly that there is much more to back pain than just disease, mechanical and traumatic factors. Do we under-appreciate the implications of stress/distress? Do we adequately reflect the insidious impact of smoking, especially heavy smoking (given that we barely gather viable information about tobacco use proclivities for underwriting purposes to begin with!)? These are questions we need to answer if we are to properly price young adult risks rather than operate in solely a reactive mode.

TEMPOROMANDIBULAR JOINT DISEASE

What you will read – if you read (and if you don't, why not?) – in the January issue of *JournalScan®* is the often-unrecognized association between this impairment and other sources of PROFOUND morbidity risk.

When you see TMJ, you think orthodontics...when in many cases you should be seeing this as a problem confronted by primary care and, not infrequently, rheumatologists.

Several major papers have shown the relationship between TMJ (that cannot be dealt with at the orthodontic level of intervention) and fibromyalgia. If we extend this to consider that FM is related to irritable bowel disease, and both are more prevalent in chronic fatigue syndrome, we come to see the folly in treating incident cases of TMJ with merely a rider or a small surcharge.

"(The) prevalence of major traumatic stressors in chronic temporomandibular disorder is high," according to De Leeuw et al. in the *Journal of Maxillofacial Surgery* (63,1[2005]:42) and a Swedish study has discovered that "impaired general health was the strongest risk factor for reported TMD symptoms" (Johansson. *Acta Odontologica Scandinavia*. 62,4[2004]:231).

Manfredini et al. (*Journal of Oral Rehabilitation.* 32,10[2004]:933) found that TMJ has a high prevalence of comorbid mood and panic-agoraphobic disorders, while Turner and Dworkin (*Journal of the American Dental Association.* 135,8[2004]:1164) threw another log on this fire when they said that "psychosocial dysfunction is prevalent among patients with chronic orofacial pain."

Don't miss the forest for the trees here.

Consider the whole risk – whether or not convenient diagnostic labels have been affixed – whenever you underwriter anyone with a history of TMJ.

When Is A Screening Pap Smear Indicated?

A comparison of the recommendations of 4 prominent, authoritative medical organizations as regards the appropriate frequency of Pap screening shows we have a way to go to get agreement on this routine screening test. Their advice to clinicians is contrasted in the January 1, 2006 issue of *American Family Physician* on page 162.

Two entities hold that women should be screened every 3 years. A third maintains that annual screening to age 30 is indicated using "traditional" cytology whereas this interval may be extended to 2 years on the basis of liquid-based methodology. The fourth authority holds that screening should be annually no matter which cytological approach is embraced.

The two that cite specific criteria for screening after age 30 are unanimous in concluding that screening should be every 2 or 3 years, differing only as to the impact of companion HPV DNA testing.

Hard To Swallow?

According to a brief report in the March 25 *British Journal of Medicine*, a Swiss court had ruled that the cost of penile implants for transsexuals should be covered by basic health insurance.

Ignorance Is Not Bliss

In a time of profitability, the focus in our industry naturally changes. Not that careful underwriting goes in the proverbial tank (at least we hope not!)...but the loss of viable business must take on even greater priority significance.

Wastage becomes anathema.

How does one minimize wastage?

One invests in expanding one's knowledge of the finer points of appraising prevalent impairments so that overly-conservative underwriting does not toss out good risks that are insurable!

The ability to realize this is anchored in NEW knowledge...and NEW knowledge is conferred only through continuing education.

This is why we created State of the Art™ CE.

Health insurers – and there are a growing number of them – enrolled in our program are about to discover major realities about overweight, obesity, underweight and weight loss that should transform their approach to these common problems.

The value of this NEW knowledge will be hundreds of times its cost...which, on an annual enrollment basis, comes to a staggering $286.

As one enrolled company observed recently: "you don't even have to have your underwriters read these courses to derive a huge payoff...they pay for themselves countless times over just in terms of amending your current practices!"

Companies that enroll in our 2006 CE program by July 31 will receive an added bonus: any 3 courses of their choosing from the 2003, 2004 or 2005 programs for FREE!

For more information, drop me a note at hankgeorge@aol.com.

GULF WAR SYNDROME... REVISITED?

Blanchard and 9 fellow epidemiologists investigated the status of 1991 Gulf War veterans 10 years out (*American Journal of Epidemiology*. 163,1(2006):66) as it relates to the chronic multisystem illness (CMI) known as "Gulf War syndrome."

What they found is, to say the very least, disconcerting.

CMI was present – 10 years later! - in nearly 29% of those service persons who were deployed in the region and almost 16% who never saw service in Kuwait. Nicotine dependence, migraine headaches and gastritis were all significantly associated with CMI.

The intriguing question is: to what extent will CMI be found among returning veterans from Iraq?

That is, on top of the acknowledged high risk of posttraumatic stress disorder...

The thinking here is that we need to underwrite conservatively, especially when reservists (who were yanked from civilian life) come home inspired by the need to buttress their coverage!

HEPATITIS C

Grant and his hepatologist coworkers (*Hepatology*. 42(2005):1406) foresee annual increases of 25% to 30% for "...hospitalizations, charges, hospital days and physician visits" due to the expanding disease burden associated with hepatitis C.

Given that somewhere between 3 and 5 million Americans are thought to be infected with this tenacious disease that translates to a surging cause of excess morbidity...

...which makes it difficult to understand why health insurers (a) don't make a concerted effort to learn more about this disease (so they won't miss obvious high risk cases that are readily identifiable) and (2) consider screening applicants at some age threshold for antibodies to the virus.

Is this going to be yet another "too little, too late" scenario, wherein senior management can scratch their collective heads as to why there are so many claims for liver disease and transplantation?

Speaking of which, phase II testing of a hepatitis C vaccine is now underway. While this could lead to a declining incidence of HCV in the years ahead, it won't do...well...squat about the clear and present danger to your bottom line!

Why Don't Trauma Center Physicians Screen More Patients For Alcohol Problems?

During my extensive research for our CE course on ALCOHOL ABUSE AND ALCOHOLISM we unearthed an "oldie but goodie" by Rivara et al published in The *Journal of Trauma: Injury, Infection and Critical Care* in January 2000 (48,1(2000):115).

The authors wanted to figure out why "...nearly 50% of trauma centers do not routinely measure blood alcohol concentrations on injured patients (and) less than 5% formally assess patients for an alcohol use disorder..."

They did. It is the reluctance of physicians to put their patients at risk for being denied health insurance benefits in trauma-related circumstances!

The authors explore some solutions, one of which is unlikely to resonate with the wishes of all genres of life and health insurance risk assessment: keeping information about alcohol screening and intervention in segregated medical files, access to which is restricted.

Night Eating Disorder

In my research on OBESITY for CE, I came across an impairment I confess to not having encountered in the past: night eating disorder (Allison and Stunkard. *Psychiatric Clinics of North America*. 28(2005):55).

To put this fascinating entity in perspective:

Bulimia Nervosa is an impairment in which the patient binges and purges.

Binge Eating Disorder is an impairment where they binge...and swallow.

Night Eating Disorder is where they binge and swallow...after sunset!

In many cases they awake in the middle of the night for some intensive grazing at the refrigerator!

The prevalence is around 1.5% of the general population but it balloons (no pun) ten to thirty fold in patients who have had (or are candidates for) bariatric (weight loss) surgery.

No fewer than 3 in 4 patients with NED have Axis I psychiatric comorbidities, most notably major depression, anxiety disorders and substance abuse/dependence.

Treatment?

What else?

SSRIs...(plus muscle relaxation therapy).

Let the record show that they don't toke out on the left over spinach either! If you didn't finish your desert, hide it under the bed!

Relative Risk For Hip Arthroplasty

It should come as no surprise that there is a steep and linear correlation between body mass index and the likelihood of needing a "hip job." Obesity has its baggage and one of the main culprits is the prolonged impact of all that extra adiposity on the weight-bearing joints.

But it is intriguing that Flugsrud and his Norwegian colleagues (*Arthritis & Rheumatism*. 54,3(2006):802) found that, in women but not in men, verticality (as in height) mattered almost as much as horizontality (as in girth).

Women in their top quintile for height had almost the same risk of eventual hip arthroplasty as those whose BMI was 30+ (that is, crossing the line from overweight to obese).

Do You Believe Everything You Read...even In Medicine?

Perlis et al. (*American Journal of Psychiatry*. 162(2005):1957) looked at the prevalence of potential conflicts of interest among physicians undertaking 397 clinical trials.

A "mere" 60% reported receiving funds from a pharmaceutical company or other some other "interested party."

Punch line?

Those who reported conflicts of interest were almost 5 times more likely to report positive trials and this subset was only statistically significant when the source of the funding came from Big Pharma.

Glucosamine, Chondroitin and Celecoxib In Painful Knee Osteoarthritis

Clegg and no fewer than 25 colleagues (*The New England Journal of Medicine.* 354,8[2006]:795) compared these two remedies to placebo and celecoxib.

Turns out celecoxib had the over-all advantage; which is to say, celecoxib provided relief to more patients than did G or C. However, in the subset with the most severe pain, G+C were superior to celecoxib.

The conclusion was that these two "alternative" remedies did not "...reduce pain effectively in the overall group..." Then, the authors allowed that their "exploratory analyses suggest" G + C, together, may be effective in those whose knees hurt the very most. This latter revelation, of course, being no great shakes as it has been known from other studies!

We won't discuss the potential conflicts of interest cited by 8 of these authors.

Developments In The War Against Nicotine Addiction

First, there is a new drug, known as varenicline which has been shown to greatly improve quitting rates among addicted smokers (*American Heart Journal.* 151,2(2006):298). When (and if) it will get through the approval maze, on the other hand, is anybody's guess. Hopefully Big Tobacco won't be able to influence the outcome!

At the same time, there are said to be 3 potential vaccines that elicit, at least in some smokers, an effective antibody response to nicotine, thus doubling the likelihood that these individuals will be able to cease and desist (*Journal of the National Cancer Institute*. 98,5(2006):301). Phase II and III studies could begin for respective vaccines as early as 2007.

Speaking About Rx...

We can't resist telling you about our next underwriting asset: Hank's Underwriting Guide to Rx.

Why would anyone lease this from us rather than relying on such things as the PDR® and Internet searches to provide what the underwriter needs?

Here are five good reasons:

We cite all the off-label uses we can find in via ongoing meticulous monitoring of the clinical literature

We provide all the necessary information about how these drugs can alter screening lab test results

We include CAUTIONS related to how dose, mode of delivery and related factors guide us to establishing the nature and severity of the impairment

We offer truly unique RED FLAGS for a wide range of potential considerations related to use of each drug that could impact insurability

Our database will be continuously updated to reflect everything of relevance in pharmacology that the underwriter needs to know

We expect our Guide to be up and running by 10/1.

All insurers who commit to leasing it (with virtually instantaneous digital access) on or before that date will enjoy 3 months of FREE ACCESS (as in, 15 months of access for the price of a year).

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