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Underwriting Psychiatric Pharmacology

If you have read any or all of my previous essays on the use of prescription drug information in underwriting, you know I am a devout advocate of making informed risk appraisal inferences based on the choice of drugs used by a physician to treat a patient.

There is an important caveat. It has to do with psychiatric pharmacology.

In 1995, I was asked to make a presentation on the underwriting implications of psychiatric pharmacology at the annual Canadian Institute of Underwriters meeting. In my preparation, I decided to find out just how many impairments might be hypothetically treated with one widely prescribed drug. I chose fluoxetine (Prozac).

I defined "hypothetically treatable with prozac" as any impairment for which a properly done study (comparing Prozac to another drug or to a placebo) had shown that Prozac was a potentially beneficial medical intervention.

From an underwriting perspective, I stopped when I had over 40 conditions, ranging from sinister (cocaine dependence) to banal (erectile failure). *Forty conditions potentially treatable with Prozac and probably a lot more now. As compared to one condition for which*

the use of Prozac was FDA-approved at that time: major depression.

My concern was to show that if someone admitted taking Prozac, there were many possible reasons they could be doing so—far too many, in fact, for any underwriter to jump to the unwarranted conclusion that someone given Prozac has major depression.

Turns out that when I also surveyed current underwriting practices of a cross-section of life and disability insurance carriers in this regard, half of them freely acknowledged that they openly embraced this untenable generalization as if it were gospel—and acted accordingly.

Since 1995, this situation has become incredibly more complicated. Off label use of psychiatric drugs is commonplace for conditions other than those for which they are FDA approved.

This is also true, by the way, for anti-seizure drugs, an increasing number of which are being actively used to treat psychiatric disorders. For example, a person prescribed gabapentin (Neurotin) or lamotrigine (Lamictal) is every bit as likely to have a diagnosis of one of the bipolar spectrum disorders as to be currently under treatment for some form of seizure disorder.

Or, consider lithium carbonate, the mainstay of treatment of bipolar disorder for so many years. Did you know lithium is also used in cluster cephalgia (a chronic headache syndrome)?

Many psychiatric drugs have also had their range of practical uses greatly expanded. A few examples may help to clarify.

Several of the most widely prescribed so-called SSRIs (selective serotonin reuptake inhibitors), of which Prozac was the first, are now being prescribed extensively to treat anxiety disorders such as panic disorder, post-traumatic stress disorder, and social phobia.

To say it differently, an applicant on Zoloft or Paxil is just as likely to have a diagnosis of anxiety as depression. While another applicant, on the anti-anxiety drug Xanax (alprazolam) could very well be diagnosed with depression or some other impairment for which anxiety is only a secondary manifestation.

The effective and widely prescribed anti-depressant Effexor (venlafaxine) happens to work very nicely in generalized anxiety disorder. Whereas the

anti-anxiety drug BuSpar (buspirone) has been found effective in some cases of refractory (treatment-resistant) major depressive disorder which have been unresponsive to anti-depressants.

Where the potential for a mistaken underwriting assumption is perhaps greatest of all is in the domain of the novel antipsychotic drugs.

This refers to a handful of relatively new drugs found to treat schizophrenia and other psychoses as effectively as phenothiazines like Thorazine, but without the potentially severe side effects that often accompany phenothiazine use.

For a thorough look of these new antipsychotic drugs from an underwriting perspective, please see underwriter Tim Shaughnessy's article in *On the Risk* (September 2001).

For the purposes of this article, one example should suffice: Olanzapine (Zyprexa) is a novel antipsychotic. It is FDA approved to treat schizophrenia. Increasingly, however, Zyprexa is being prescribed (in much lower doses) to treat patients who have less serious, potentially more insurable impairments.

An applicant on 20 milligrams or more of Olanzapine each day most likely has a diagnosis of a psychosis. On the other hand, one given only 2.5 mg tablets, to be taken as needed up to several times a day, is much more apt to suffer from depression, or possibly even an anxiety disorder, as the root cause of his symptoms.

There are two points to this.

1. **Avoid the temptation to make a final underwriting decision based solely on knowing that an applicant takes one particular psychiatric drug.** A better approach is to do a telephone interview or order an APS as circumstances dictate, and take a look at the rest of the story. Remember, context is everything. Two people may take Zyprexa. One may be preferred and the other uninsurable. This determination cannot be made from a simplistic mindset (e.g., Zyprexa equals psychosis equals decline).

2. **Seek out the dosage from the applicant.** Dosage may serve well as a key mitigating factor. The situation with Zyprexa makes this point in spades.

Good luck...and good underwriting. o