Claims & Underwriting

Stump the Chump - Medical Directors Forum

Producer:

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ILTCI

Claims & Underwriting

Cannabis

James Wright, MD

ILTCI

High Level Demographics

- Legal for medical treatment: 28 states and the District of Columbia
- Legal for recreational use: 8 states and the District of Columbia
- In 2015, 22.2 million reported use within the past month (8.3% of 265 Americans ≥12 years old)
- Prevalence of use correlates with:
  - Age: 20% of 18–25 year olds; 4% of those >50
  - Ethnicity: Blacks > Whites > Hispanic > Asian
  - Sex: Male>Female
  - Education: College > High school or less > College graduates
  - Income: Less income > More income

LTC Concerns

- Mortality
- Morbidity/Disability

- Age
- Frequency of use
- Route of administration
- Prescribed or recreational
- Evidence of complications
- Evidence of dependency

What's the Science

- "The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research"
  - National Academies of Sciences, Engineering and Medicine, 2017
  - Analyzed >10,000 studies
- Marijuana's FDA classification as a Schedule I substance has restricted research, so useful data is limited

What's the Science? Health Effects

- Cancer – no evidence to support
- Cardiovascular – may increase MI risk acutely. Limited evidence of acute increased stroke risk.
- Respiratory – chronic bronchitis with regular use
- Mortality – Insufficient data to support or refute an association between cannabis use and all-cause mortality. Mortality is possibly increased related to MVAs.

What's the Science? Health Effects

- Substance abuse - moderate association between cannabis use and use of or dependence on alcohol, tobacco and illicit drugs
  - Odds ratio greatest in adolescence with rapid decrease after mid-20s.
- Mental health
  - Increased risk of development of schizophrenia and other psychoses
  - Possible increased risk of developing bipolar disorder
  - Small increased risk of developing depression
  - Weak association between cannabis use and anxiety disorders
- Problem cannabis use – risk is greater in males and increases with frequency of use

Case Presentation

Case Presentation: 65 year old woman with irritable bowel syndrome found that MJ eases the occasional symptoms of irritable bowel. She didn't like smoking it so she eats commercially prepared cannabis cookies on an as-needed basis, typically several times a month.

You're the Underwriter…

- How would you underwrite this applicant?

You're the Underwriter

- How would you rate this case?

1) Chill, dude! This is no big deal.

2) I would offer smoker rates. I'm sure she must continue to smoke sometimes.

3) Rate this case…what are you smoking? I'd decline it!

You're the Underwriter

- Would your rating change if she used a cookie most days?

1) I'd ask more questions:
    1) Has frequency increased?
    2) Why is she using a cookie most days?
    3) Does frequency of use matter?
2) I would consult with Medical to see if it makes a difference in the rating.

You're the Underwriter

- Would you feel differently if her doctor prescribed the marijuana?

1) No, pot is pot.

2) Yes. Medical supervision means less risk of abuse.

3) I would consult with Medical to see if it makes a difference in the rating.

HIV

Stephen Holland, MD

Underwriting HIV

56 year old male, applying for TQ LTC $350/day, 6 years, 90 day EP, couples discount

- Corporate executive, active, exercises daily
- HIV+ since 1992, on HAART, with good compliance
- No history of HVB or HVC, no IV drug use, nonsmoker
- Recent CD 4: 600/cmm; Viral Load: 350 particles/mL
- Hypertension on metoprolol with good control

You are the Underwriter . . .

- How would you underwrite this applicant?

You are the Underwriter

How would you underwrite this history of HIV+?

1) No, never – are you out of your mind?
2) Yipes, I have no idea! I would turf this case to our Medical Director.
3) We would offer limited, Substandard coverage to those HIV+.
4) We underwrite cases such as this and we would offer a range of LTC coverage and classifications.

Underwriting HIV Risk

42 year old male, applying for TQ LTC $350/day, 6 years, 90 day EP, couples discount

- Business owner, active, exercises daily
- HIV negative
- On Truvada since 2012; HIV negative, good compliance
- No history of HVB or HVC, no IV drug use, nonsmoker
- Hypertension on HTCZ, with good control

You are the Underwriter . . .

- How would you underwrite this applicant?

You are the Underwriter

How would you handle this 42 year old married male applicant taking Truvada on regular basis (i.e., PrEP therapy)?

1. Run for the hills! We would not underwrite an applicant on this medication.
2. Yipes, who knows? I would refer this case to our Medical Director.
3. We would carefully underwrite this case and offer limited, Substandard LTC coverage.
4. We would underwrite this case and offer a range of coverage and classifications.

HIV and AIDS

- HIV infection first identified in 1981
- 1.8 million Americans have HIV and ~650,000 have died
- Currently 1.1 million HIV infected individuals in the US
- Approximately 50,000 new HIV infections a year
- Mortality rates due to HIV have dropped markedly since the introduction of HAART, producing a near normal life expectancy
- Many Life Carriers now offering 10-20 year term coverage
- Use of PrEP therapy in non-infected individuals is close to 99% effective in preventing HIV infection when taken daily

HIV and LTC Underwriting

HIV Infection

- HIV+ LTC policyholders have experienced less than expected claim incidence and short durations
- AIDS associated with significant compression of morbidity
- Underwriting Approach
  - HIV viral loads very low; no history of AIDS or Rx complications
  - Adequate CD 4 counts, good Rx compliance on HAART
  - No history of HBV or HCV infection or IV drug use, no smoking

HIV Prevention - Truvada

- Emtriva (emtricitabine) and Viread (tenofovir disoproxil fumarate)
- 92%-99% reduction in HIV risk for HIV-negative individuals
- PrEP can be safely considered for some form of LTC coverage

Depressive Pseudodementia

Wayne Heidenreich, MD

Pseudodementia

- Underwriting
  - 57 yo female NT
    - Depression treated with buproprion, venlafaxine, and clonazepam and psychotherapy
    - Osteoporosis: 4'10" on Fosamax®
    - Admits to Dx of "false dementia" 2 years PTA
  - Primary care MD APS
    - 1.5 years PTA had c/o gradual onset of memory complaints
    - Worsened after being trapped in a hotel room during a snow storm with panic attack
    - Developed problems with word finding, concentration problems, and confusion over "who she was talking about."

Neuropsychological testing

- Psychiatrist: on fluoxetine, buproprion, and benzodiazepine (records not obtained)
- Neurologist: non-focal exam; normal CT and EEG
- Neuropsychological (NP) assessment
  - CC: one year of worsening memory
  - NP testing normal except for “limited cognitive flexibility”; life is “black and white”
  - Some loss of interest in normal activities and socialization declining, tearful during interview
  - MMPI: depression and anger
  - Diagnosis made of “depressive Pseudodementia”

Diagnosis of "Pseudodementia"

- Underwriting Requirement of a F2F interview
  - Freelance art critic with Master's Degree
  - Side business of antique dealer
  - MMSE of 29 and DWR of 10/10
    - Attributes memory loss, confusion, and forgetfulness to her child's illness and caring for elderly parents.
    - Has been functional again for about a year on buproprion and venlafaxine, with clonazepam being discontinued.

You're underwriting this

Can you issue a policy now?

1. Yes. Neuropsychological testing is the gold standard and there was/is no significant cognitive impairment.
2. No. Depression uncovered a cognitive deficit of reduced reserve. Advise no reapplication.
3. I'm confused. Isn't this a claims case?
4. Maybe, in the future. But these symptoms are just too recent and we would require an "adjustment period" with some sort of retesting.

The claim

- Admitted 4 years post-issue: possible seizure.
  - MRI possible “amyloid”: multiple intracerebral hemorrhages.
  - Family very concerned re: memory.
- Age 63 admitted 6 yrs post-issue: Fall; seizure?
  - Generalized weakness.
  - Short term memory problems, confusion and anxiety.
  - Alcohol detox done
- At age 63 D/C to ALF for supervision.
  - On restricted floor.
  - Rebab for gait strength and self-care
  - Goes from walker to independent gait
  - ADL’s with supervision and cueing

Long history. What was missed?

- Outpatient Neuro visit 1 mo. post-discharge: gets lost going to bathroom in office building.
  - Interim “10 years” diagnosed with bipolar disorder. Put on lamotrigine, venlafaxine, and the atypical antipsychotic, olanzapine. Prn diazepam. Also put on galantamine (Razadyne®) in hospital.
  - Lived at home with a college student helping her with her antique business.
  - Increasing use of alcohol led to medication non-compliance
- A retrospective review of NP records.

Pseudodementia

- Defined
  - Intellectual impairment with psychiatric Dx
  - Reversible
  - Features resemble neuropathological disease
  - No apparent neuropathological disease
- Primary conditions: major depressive disorder, bipolar disorder, schizoprhenia

Long-term prognosis for Pseudodementia

- Prodrome or Risk Factor?
- Most studies done in “elderly” over age 65 and very heterogenous
- As Prodrome?
  - Once mood stabilized, still have cog dysfx
  - Lower mean MMSE scores after Tx
  - Higher rate of MCI after resolution
- As Risk Factor?
  - **Depression found to increase relative risk rate for dementia by 2-4 times**
- Learnings?

Kennedy J Depressive Pseudodementia – how ‘pseudo’ is it really? *Old Age Psychiatrist* 2015; 62: 1-7