Claims & Underwriting

Stump the Chumps

Heidenreich and Holland

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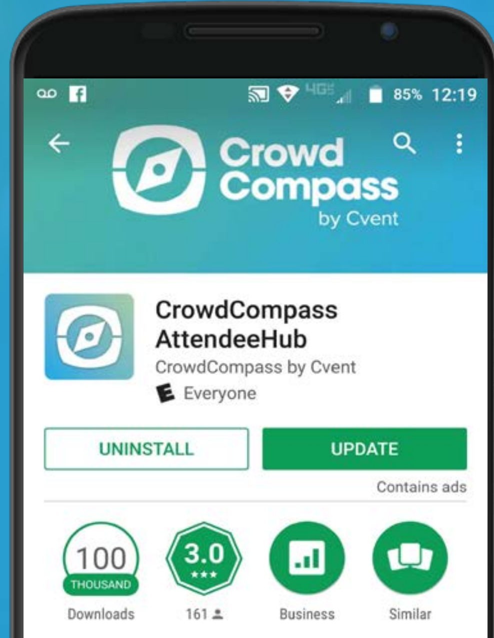

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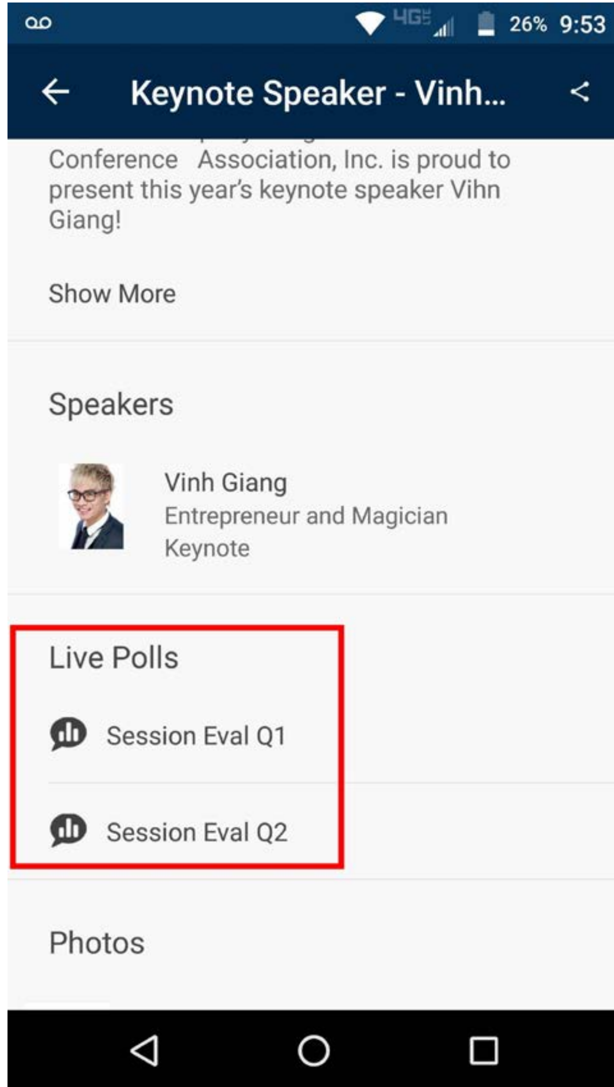

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Claims and Underwriting Questions in case the audience is asleep

A Most Common Source of Angst

- 71 yo female for $7500 MMB, TQ LTCi, 6 year BP, 12 week BD.
- Underwriting in 12/2017
- Application Medical Questionnaire:
  - Admits to Anxiety taking trazadone, escitalopram, and alprazolam 0.25 mg
- APS Medical Records; Primary Care MD
  - Anxiety for 10 years.
    - 2014 alprazolam 0.25 mg 2 x / day documented
    - 2015 alprazolam 2 x / day, sometimes 3 x / day

Angst Case Continued

- 2015 April: very anxious over husband's illness
  - Escitalopram, an anti-depressant, added
  - MD recommends trying to wean down the alprazolam dose
  - Insured agrees but "now is not the right time"
- 2015 through 2017 taking 2 doses of alprazolam
- Spouse dies of cancer in September 2017
  - trazadone at bedtime added for problems sleeping
    - 2nd anti-depressant with sedating side effects
- LOV: alprazolam 1-2 per day, mostly 2 per day
- In person F2F cognitive screening very strong with DWR 8/10

Case Discussion

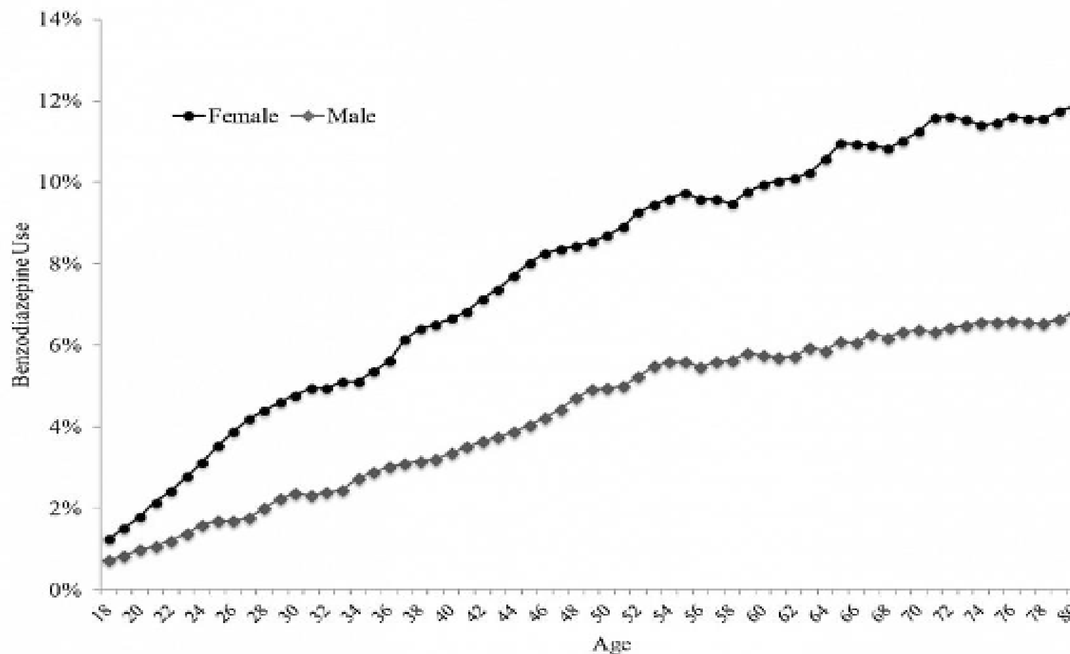
- Diagnosis never made beyond "Anxiety"
- Probable diagnoses include:
  - Generalized anxiety disorder
  - Adjustment disorder with anxiety
  - Grief
  - Benzodiazepine dependence
- What are her risks?

Things to consider

- Alprazolam is a rapid onset benzodiazepine related to diazepam (Valium®)
- Adult dosing of alprazolam for anxiety: Initial dosing 0.25 mg to 0.5 mg given up to 3 x day
- Maximum dose 4.0 mg / day
- The elderly are the highest users of benzodiazepines
- Generalized anxiety disorder (GAD) and adjustment disorder with anxiety
  - Benzodiazepines can be effective initially.
  - Anti-depressants are also used and are effective because depression is often a co-morbid.
  - Dependence

The elderly are the highest users of benzodiazepines

- Despite clear recommendations by the American Geriatric Society against use of benzodiazepines in the elderly, defined as over age 65, nearly 12% of females age 80 are prescribed them.



https://www.nih.gov/news-events/news-releases/despite-risks-benzodiazepine-use-highest-older-people

A paradox

- In U.S. 10% of women and 6% of men age 65-80 have at least one Rx filled in 1-year period.
  - one third for > 120 days
- The elderly are the highest users of benzodiazepines.
  - primarily for GAD and for insomnia
- All anxiety disorders in general are less prevalent in individuals older than 65 than in younger individuals.
- Recommendations regarding not using long term benzodiazepines based on “moderate” evidence but are “strong.”
  - “Strong evidence” for avoiding
    - History of falls
    - Already on 2 medications that depress the CNS

Hypnotics

- Non-benzodiazepine hypnotics for sleep are not to be used beyond days.
  - eszopiclone (Lunesta®)
  - zaleplon (Belsomra®)
  - zolpidem (Ambien®)
- Increased risk for delirium, falls, fractures, MVA's.

Dependence

- Features
  - Long-term use
  - Rebound anxiety and withdrawal
  - Strong desire for then
  - Driving while under the influence
  - Use despite falls
  - Use despite other hypnotics
  - Use despite MD recommendations
- Sedative, hypnotic, or anxiolytic use disorder 1-year prevalence diagnosed in only 0.04%

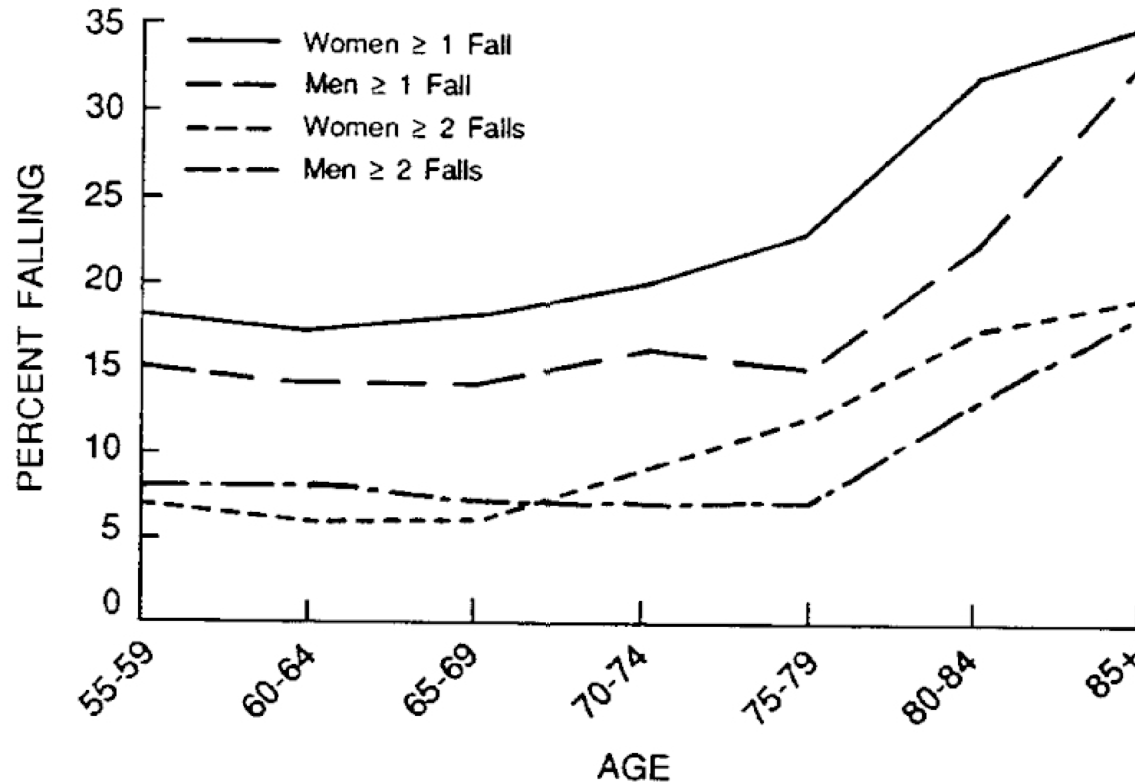
Can we quantitate risk?

- Fall risk with benzodiazepine is significant
  - Fall with fracture
    - dose dependent
      - Starts at equivalent dose of
        - » lorazepam: 0.3 mg/day
        - » diazepam: 3 mg/day
      - Using equivalency tables these doses are:
        - » alprazolam: 0.150 mg/day
        - » clonazepam 0.375 mg/day
  - Increases risk of fall by 50%

https://emedicine.medscape.com/article/2172250-overview Markota M, Rummans A, et.al. *Mayo Clin Proc*, 2016; 9(11): 1632-39.

Increased morbidity risk

- Reported falls in last year
  - 65-74: 1 in 4
  - 75+: 1 in 3
- With benzos 50% increase =>
  - 65-74: 1 in 3
  - 75+: 1 in 2
- One half fall 2 or more times
- One quarter of falls => decreased activity
- One half living at home and hospitalized due to fall do not go home



https://www.ncbi.nlm.nih.gov/books/NBK235616/pdf/Bookshelf_NBK235616.pdf *The Second Fifty Years; Promoting Health and Preventing Disability,* 1992; National Academy of Science.

- National Health Interview Survey's 1984 Supplement on Aging.

Summary

- Physiologic dependence in weeks.
- Withdrawal exacerbates anxiety and insomnia the symptoms usually being treated.
- Treatment of the elderly with benzodiazepines *is* associated with decreased cognitive function.
- Increased mortality is seen from 1.2 to 3.7 times the rate of unexposed.
- Significant morbidity associated with falls.
- So… is your product priced for daily sedative use?

Underwriting Question

What is your approach to a family history of dementia?

1. We would decline an applicant with a strong family history of dementia (at least a sibling and parent)
2. We do not consider a family history of dementia when we underwrite an application
3. We will consider a Substandard offering for a strong family history (at least a sib and parent)
4. Yipes, I would turf a strong family history to our Medical Director

Cognitive Complaints in an APS

Underwriting Question

How do you handle a family complaint of memory issues noted in an APS?

1. We ignore the complaint since it's only a family report
2. We would be concerned and we would require cognitive screening
3. We would require a statement from the applicant's PCP describing normal cognitive function
4. We would decline the application

Claim Question - Inconsistencies

What is your approach to a TQ claimant who presents with a diagnosis of dementia and a score of 29/30 on their MMSE?

1. The diagnosis of dementia is sufficient, we would approve
2. The MMSE score is normal, so we would decline
3. We would reach out to the claimant's doctor for information on the extent and severity of dementia
4. We would look for dementia medication and then the level of care required for the dementia

Claim Question - Inconsistencies

How do you approach a claimant who states that they are dependent upon human assistance with bathing and dressing but also admits to continuing to drive around town?

1. No way – how can you control a 2000 pound projectile yet be unable to bathe or dress independently?
2. It happens, but it causes us angst so we always dive deeper into their bathing and dressing ADLs
3. We ignore the fact they are driving if their assessment or agency care plan states that the claimant cannot bathe and dress without assistance

Claim Question - Inconsistencies

Under a TQ LTC plan, how would you approach a claimant who only has care with bathing and dressing one day a week?

1. If there is no informal care, we would question a bathing and dressing claim if there is only care one day a week

2. It happens and we've approved this in the past, but we would attempt to understand if the claimant was truly bathing and dressing dependent

3. We would approve the claim if we determine that the claimant has bathing and dressing dependency regardless of the one day of care a week careplan

Claim Question - Inconsistencies

Do claimants under a TQ plan who are approved for a cognitive impairment ever recover or will they necessarily exhaust their benefits or die in claim?

1. Dementia? Dementia is a terminal illness and these individuals never recover
2. It all depends on the diagnosis – sometimes the diagnosis is wrong and recovery is possible
3. We review every claim anticipating a recovery and we see recovery in encephalopathy, depression, an acute event overlapping mild cognitive impairment, etc.

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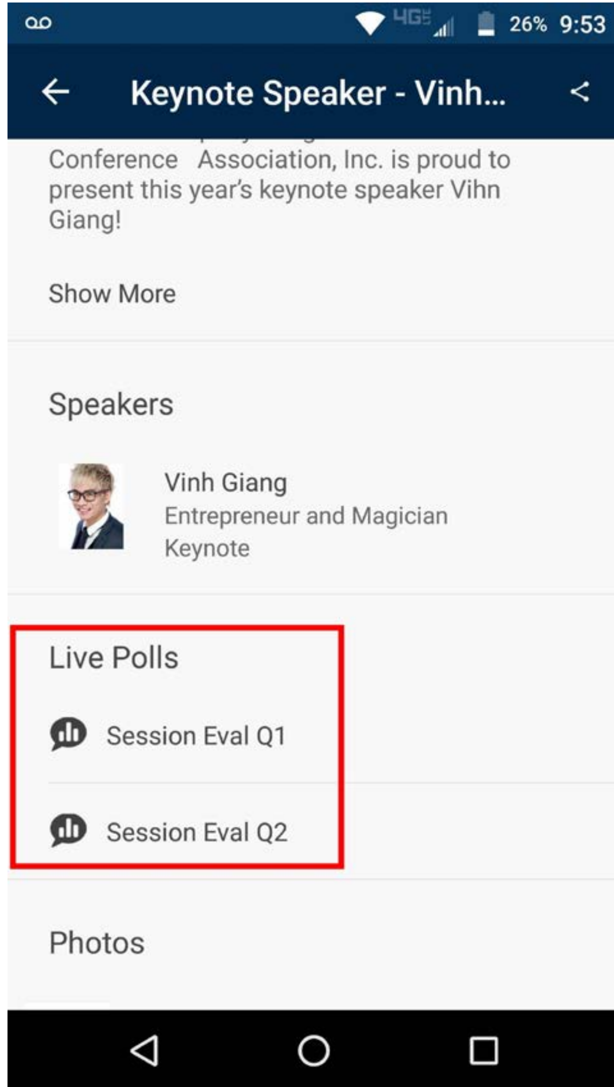

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