Underwriter's Corner

Competitive offers (Part 3)

This issue will address competitive offers and will cover medical conditions from letters P through Z and ends our extensive series on this topic. It is our hope this series has allowed you to reflect on your underwriting thought processes on a variety of medical topics as well as to consider ways to make more competitive offers.

- **Psoriatic arthritis:** In general, we should first consider if an applicant is taking medication. Possible medications prescribed for psoriatic arthritis include NSAIDs, disease-modifying anti-rheumatic drugs (DMARDs), immuno-suppressants, TNF-alpha inhibitors (including Remicade, Humira, Simponi, Cimzia). After considering the medication, the severity of the disease should also be considered. Those with mild to moderate disease could be considered at standard while those with moderately severe to severe disease could be considered at low sub std and up.

- **Pulmonary HTN**: It can be difficult to determine what to do with pulmonary hypertension on an echocardiogram when there are no other significant findings. The degree of pulmonary hypertension is measured on an echocardiogram by the systolic pulmonary artery pressure. When there is no underlying disorder of CAD or significant valve disease and mild findings are seen on an echocardiogram, these situations could be considered without a rating with the appropriate medical referral. Those with more than mild pulmonary hypertension should be considered with significant caution due to increased mortality.

- **Replacement of joints:** When an applicant applies for life insurance with a recent joint replacement of the hip or knee, it can be difficult to determine if an offer should be made or if a postpone for a short period is more prudent. There can be mortality concerns during the first few months post-operatively due to possible blood clots which in some cases can result in a heart attack, stroke or pulmonary embolism. Before offering coverage, the cause for the joint replacement should also be considered. It may be due to osteoarthritis, osteoporosis, or other medical conditions such as rheumatoid arthritis, psoriatic arthritis, etc. After a joint replacement, coverage should be postponed at least 3 months to ensure there are no unexpected complications such as a blood clot, which could prove to be a fatal event.

- **Sleep apnea:** When there is no sleep study but there is suspected sleep apnea, we should rate based on the symptoms or EPS. Another consideration for those with treated sleep apnea is the post-AHI level. If a patient originally had moderate to severe sleep apnea but is using a CPAP regularly and has a favorable follow-up, sleep study be sure to consider the follow-up AHI in your rating assessment. This could allow you to make more competitive offers on patients where good control is known.

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- **Solitary pulmonary nodules:** Sometimes it is difficult to figure out what to do if you have a solitary lung nodule noted on a CT when the etiology is unclear. Is a repeat CT scan needed? Do we need 1 or 2 repeat scans before we offer? What if the person is a smoker? The Fleischner Society has specific recommendations for necessary follow-up on solitary pulmonary nodules. Low risk patients are those with minimal or absent history of smoking and no other known risk factors. High risk patients are those with a history of smoking or other known risk factors.

Nodule size	Low Risk patient	High Risk patient
< or equal to 4 mm	no follow-up needed	CT at 12 months
> 4-6 mm	CT at 12 months	CT at 6-12 months and then at 18-24
> 6-8 mm	CT at 6-12 months and then at 18-24 months	CT at 3-6 months, then 9-12 months and then 24 months
> 8 mm	follow-up at 3,9 and 24 months with CT, PET and/or biopsy	follow-up at 3,9 and 24 months with CT, PET and/or biopsy

- **Thyroid nodules/goiter** When a nodule(s) is located, a TSH level and thyroid ultrasound are typically obtained. How can an underwriter evaluate when a malignancy is suspected? At what size is a biopsy suggested? A low TSH level indicates hyperthyroidism and the risk of thyroid cancer is very low. There are many different recommendations about when to perform a biopsy based on the size, composition, symptoms, evidence of micro-calcifications, family history, etc. In general though, it is concerning if a nodule is 1 cm or larger or if there are any suspicious ultrasound features.

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Case Studies

Case Study #1 Male age 45 for 400,000

Psoriatic arthritis diagnosed 3 years and currently on Arava. There is no history of hospitalization. X-rays show some erosive findings but he is doing well with limited joint problems. He is followed by a rheumatologist every 3-6 months.

This would be considered a moderate category of psoriatic arthritis due to the medication taken and could be considered at std to low substd depending on the rest of the medical history.

Case Study #2 Female age 67 for 1,000,000

A hip replacement done 4 weeks prior to the application date due to advanced osteoarthritis. She was discharged on Coumadin and is now discontinuing this medication, per her physician’s advice. She is currently going through rehabilitation with physical therapy.

In this situation, it would be prudent to postpone this file until she is 3 months post-operative.

Case Study #3 Male age 55 for 300,000

History of sleep apnea for 10 years and he states on his paramedical that he is compliant with CPAP. His APS shows that he had a history of severe sleep apnea with an AHI of 55. A follow-up sleep study done last year shows that the CPAP was effective and his AHI was < 10. There were no arrhythmias or other concerns noted on this sleep study.

In this situation, the manual suggest to rate in the controlled sleep apnea category at severe for ages > 51 at substd. However in this situation with good compliance and a favorable AHI of < 10, this can be considered more favorably at standard.

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Case Studies

Case Study #4 male age 68 for 2 million

A CT scan was done for some abdominal pain. The CT scan showed with no concerning abdominal findings and a lung nodule was noticed measuring 3 mm. The patient is a non-smoker and has no family history of lung cancer. Follow-up was mentioned as optional on the CT scan for the lung nodule but his physician did not feel it was necessary. Should we accept as is?

Based on the Fleschner recommendations, this small lesion would be acceptable to allow with no further follow-up in a low risk patient.

Case Study #5 40 year old Female for 350,000

An enlarged thyroid was noted on physical exam by her physician, and she was recommended to have a thyroid ultrasound. Her TSH level is normal. The ultrasound showed multiple nodules all less than 1 cm. The nodules ranged in size from 3 mm to 9 mm and a follow-up ultrasound was recommended in 12 months. Can we offer with what we have or is follow-up required before offering? Is a rating necessary?

In this situation with a normal TSH and favorable thyroid ultrasound

Case Study #6 70 year old male for 500,000

A stress echocardiogram done for some shortness of breath showed no valve issues but there was an increased systolic pulmonary artery pressure of 34 (normal up to 30). There was no ischemia or infarcts seen. The diagnosis was mild pulmonary hypertension and repeat stress echocardiogram was recommended in 1-2 years. The shortness of breath was felt to be related to deconditioning. There was no other concerning medical history. Should we rate?

This stress echo demonstrates no significant CAD or valve disease. Therefore, a standard offer would be reasonable with the appropriate MD referral.

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