Underwriter's Corner

Older Age Underwriting

Underwriting the mature age applicant can be challenging because there are many impairments that are handled differently than traditional underwriting. One of the underwriting traps to fall into is over-debiting. The same ratable medical condition in a 51-year old versus a 75-year old may be less important in the 75 -year old. Let's look at some impairments that need special attention in the elderly:

- **Kidney function tests:** As a person ages, the kidney goes through changes which can increase the creatinine levels and reduce the glomerular filtration rate (GFR). A mildly increased creatinine can be much more concerning at a younger age than at an older age. When underwriting the elderly, you should calculate the GFR from the paramedical labs and record this on your underwriting worksheet. It is helpful to look for the overall trend of the GFR in the file to ensure stability. A decreasing GFR is much more concerning than a long-standing stable GFR in an elderly applicant. You may be able to offer more favorably with a long-standing stable GFR, with the appropriate MD referral. Reminder that the creatinine and GFR will not be valid when there is hemolysis seen on the paramedical labs.
- **Falls and fractures:** These should be considered with more caution in the elderly. When reviewing an APS, you should try to determine the cause of the fall. Was the fall a slip on the ice or an unexplained fall? Please be extremely cautious with a hip fracture. Sometimes it is better to postpone hip fractures for a significant length of time, due to excess mortality.
- **Depression:** This can be difficult to underwrite in the elderly. Looking at the longevity of the depression as well as the cause of the depression is important in underwriting. Is it situational, longstanding, or the result of a cerebrovascular process such as the first onset of dementia? Depression can also impact other disease processes in the elderly making those harder to control. Depression in the elderly should be considered with caution, since it is sometimes harder to quantify the impact.
- **Diabetes:** When an applicant has diabetes with onset later in life, it has much less impact than when it is diagnosed at a younger age. For example, two applicants have new onset well-controlled diabetes: One is age 51 and the other is age 75. Underwriters expect a 51-year-old to have limited medical concerns, so when looking at what is standard in a 51-year-old, the limits are more stringent. The normal 75-year-old often has many problems, and that is typically reflected in the mortality assumptions and the pricing. You can sometimes make more favorable offers in the elderly with the appropriate MD referral.
- **CAD:** While the likelihood of CAD increased with age, the progression of the disease in the elderly is much slower. This may allow for ratings that are more favorable with the appropriate MD referral.
- **Echocardiograms:** Some of the valve issues seen in the elderly can be considered "age-related," and you may be able to offer more competitive ratings with the appropriate MD referral. Examples would include valve disease and also some enlargement of the aorta and atrium.
- **Weight:** In the elderly, it is good underwriting practice to document your worksheets with the weight over a 1–2 year period to ensure stability. While a 10 pound weight difference may be insignificant in a 40 year old, it may indicate an underlying issue in an elderly applicant. Also, elderly applicants do not typically lose weight with diet and exercise. A 5 to 10% weight loss can be significant in the elderly. However, when an elderly applicant is OVERWEIGHT, it is viewed more favorably.

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- **Frailty:** This is commonly seen in the aging process but not everyone becomes frail. Frailty can be defined as a lack of reserve, and is concerning because it tends to portray a poorer outcome. There is a higher risk for major adverse health outcome including disability, falls, hospitalization, and poor mortality. The applicants that are typically frail are more commonly women, since they tend to live longer than men. Key identifiers of frailty are social isolation, dependency in managing life activities and self-care, cognitive decline, decreased bone and muscle mass, and weight loss.

- **Labs**: When reviewing the elderly, there are some differences in how labs should be reviewed.

  Complete Blood Count (CBC): Closer attention should be given to the review of CBC's in the elderly to look for anemia and increased lymphocytes. Often the first signs of an undiagnosed or recurrent cancer is new onset anemia. When new onset anemia is noted, use caution and consider postponing unless an evaluation has been done to determine the cause. However, stable anemia, may be less of a concern. Close attention also needs to be given for chronically increased lymphocytes because this may be an indication of new-onset chronic lymphocytic leukemia (CLL).

  Cholesterol: As an individual ages, cholesterol tends to tends to increase slightly. The risk factors associated with an increased cholesterol are not as significant in the elderly applicant. You may be able to consider an elderly application with increased cholesterol and other favorable factors more liberally. However, a new finding of low cholesterol (when not on a statin) should be regarded with closer scrutiny.

  Serum albumin: In the elderly, a low albumin can be concerning. Low albumin can be related to poor nutrition, kidney dysfunction, liver disease, congestive heart failure, cancers, etc. As the albumin decreases to levels of 3.5 or below, the mortality increases significantly. Low or decreasing albumin should be regarded with closer scrutiny.

- **Memory**: It is difficult to underwrite memory because it is often not reported to a physician until significant issues exist. Many companies do not test for cognitive issues on their paramedical exams with Delayed Word Recall, Clock Draw, etc. Even with these tests though, it is sometimes difficult to quantify and interpret the findings to determine if there are significant memory concerns. Even the MMSE (mini-mental status exam) cannot diagnose the EARLY stages of Alzheimer's disease. Looking at the overall picture with a close review of the medical records may give us a better indicator of any possible memory issues. Continue to refer any possible memory concerns to our medical director.

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- **Family history:** Family history is much less important in the elderly. For an older applicant, concerns such as cancer and heart disease which are related to family history will likely have emerged by the time of the application. However, family history can still remains a useful factor. Its significance emerges when examining longevity in family history. An applicant whose parents lived a long life will more likely do the same when compared to other applicants whose family history is different. Special credits are available in the build section for longevity as well. Be sure to look for these.

- **Financial underwriting:** In the older age market, use caution when you notice IAI hits. You should consider asking the details of the applications/face amount applied for in the past. Seeking coverage later in life is expensive, and you should to be cautious of possible anti-selection. If an applicant is applying for a very large face amount, it is in the best interest to review closely due to the potential for life settlements and STOLI (stranger-originated life insurance).

When reviewing medical records on elderly applicants, the acronym ASCENT is helpful to remember:

- **A**DL's, IADL, and AADL
- **S**ocial interactions
- **C**ognition (Memory)
- **E**xercise Capacity
- **N**utrition
- **T**rips

In summary, while his article cannot address all the unique aspects of older age underwriting, hopefully it will allow you to consider the unique challenges and characteristics of the older age market.

Underwriter's Corner

Case Studies

Case #1: 6 million 75 year old Female

Application was dated 1/2013. APS showed a history of anxiety/depression for many years, well controlled on Prozac. 2/2012 build 5'4'' 146 pounds and advised to follow a low calorie diet. 6/2012 chronic fatigue due to caregiver syndrome, 146 pounds. 9/2012 seen with stress caring for her spouse with weight loss of 12 pounds to 134 pounds. 1/17/2013 paramedical build of 5'5 128 with admitted 10 pound weight loss in the past year. In 2/27/2013, the APS showed a stable weight of 128 pounds. A letter from her physician states "She was advised a little over a year ago to reduce her weight in order to achieve a healthy BMI. Currently her BMI is in the healthy range. She has been encouraged to maintain a nutritionally healthy diet and regular exercise."

There was an 18 pound weight loss in the last year but her BMI was still normal. This was approved standard in 4/2013 with the assumption that the weight loss was intentional and possibly due to stress. She was diagnosed a few weeks later with metastatic colon cancer and died in July 2013.

TAKE HOME MESSAGE: Be very cautious with weight loss in the elderly even when the explanation may seem reasonable.

Case Study #2: 100,000 Female age 85

Application was dated 8/6/2014. Paramedical shows well-controlled HTN and occasional gastritis. APS shows that she is seen every 2 months with HTN, BP readings normal. Also has long-standing well-controlled depression, and stage 3 kidney disease, stable for years with most recent labs showing BUN 32, creatinine 1.4 and GFR 43. She was seen on 7/24/2014 with abdominal pain, aggravated by eating, nausea and vomiting. She tested positive for H. pylori and was started on treatment. The pain was incapacitating, interrupting her sleep. She was Rx Compazine and Prilosec and seen the next day on 7/25/14 with abdominal pain improved, able to hold down fluid and eat yogurt but still tired. No further APS information was available.

The HTN, stable kidney disease and depression are not too concerning on this applicant. In a younger applicant, the abdominal pain with a diagnosis of positive H. Pylori would not have been overly concerning. However in a 85 year old, these symptoms are very concerning. With poor eating, we should decline and only reconsider if there has been a formal GI workup with a scope and enough time elapsed to show complete recovery with no continued complaints.

TAKE HOME MESSAGE: Recent complaints in the elderly should be regarded with closer scrutiny.

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Case Studies

Case #3: 100,000 Male age 73

History of bladder cancers, all superficial transitional cells with no invasion and treated in 2003, 2004, and 2010. Follow-up cystoscopies all normal. Diabetes diagnosed 3 years ago. 7/2014 Paramedical labs show HbA1c of 7.4, creatinine 1.4, BUN 29, EGFR 50 with some hemolysis noted. Anxiety and depression treated with Lorazepam, Buspirone, and Paxil with no mood complaints for several years. APS labs shows 2011 labs with creatinine 0.9, GFR > 60, CBC lymphocytes 7.3 (2.9) and WBC 12.6 (10.8). 12 /2013 creatinine 1.08 with GFR > 60. 3/2014 creatinine 1.09 with GFR > 60, CBC lymphocytes 8.69 (2.9) and WBC 15 (10.8).

In this applicant, the bladder cancer is not a significant concern, and the diabetes could be considered with a small rating. The paramedical labs showing a lower EGFR should be considered a lab error due to hemolysis. It is not a concern especially since we have normal GFR's in the APS. The depression is longstanding and is also not a major concern. In an elderly applicant, the CBC findings should raise concern for a possible chronic lymphocytic leukemia (CLL). With CLL, the incidence rises with age. Males are twice as likely to develop CLL as females. and it is often diagnosed by an incidental finding of increased lymphocytes on a CBC. This file should be declined, due to the CBC findings with possible concerns for an undiagnosed CLL.

TAKE HOME MESSAGE: Look closely at CBC's in the elderly for anemia and abnormal lymphocytes.

Case #4: 100,000 Male age 75

Paramedical build of 5'6 256 with well-controlled hypertension in a nonsmoker. There were no other concerns on his medical history. He is active in the community and both his parents lived into their mid 80's.

With a build of 5'6 256, typically could be assessed at low ssub std, but with favorable credits for nonsmoker and older age, you could consider this at standard.

TAKE HOME MESSAGE: To make more competitive offers, use the older age credits in our manual.

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Case Studies

Case Study #5: 250,000 Female age 72

Cardiac catheterization in 2010 showed normal ejection fraction and normal coronaries. 2012 Echocardiogram shows mild LVH and mild LAE 4.2 (4.0). Echo was done due to palpitations, with a diagnosis of paroxysmal atrial fibrillation (PAF) requiring cardioversion. There was recurrent PAF in 9/2013 with further investigations showing a normal CTA. CBC platelets 108 (130) in 2012 and currently 113 (130).

We assessed this as PAF low rating, and thrombocytopenia moderate rating. In this case a more aggressive offer would have been possible by not rating as heavily for the thrombocytopenia and PAF. In thrombocytopenia, we can consider more favorably in an asymptomatic person with all other CBC findings normal, no history of bleeding, stable platelet findings, and continued platelets of greater than 100,000 without a rating. These files can be referred to our MD for approval without a rating, if the above criteria are met. Also a reminder that when rating for atrial fibrillation to review the credits. With a favorable catheterization, echo, or CTA, significant credits are available.

TAKE HOME MESSAGE: Thrombocytopenia can be standard if the platelets are over 100,000, along with other favorable characteristics.

Case Study #6: 2 Million Female age 73

APS information shows well-controlled HTN on medication with regular follow-ups. The APS shows a stable GFR of 45 in 2004, 43 in 2008, 42 in 2010, 42 in 2011, 2012 and 2013 and current GFR on her paramedical labs is 42. Other than her stable low GFR, she is in excellent health.

Our manual suggests low substd for GFR of 40-45. She has had a stable GFR for 10 years. With long-term stability, this is a file where a better rating may be possible with the appropriate MD referral.

TAKE HOME MESSAGE: The manual is a general guide but we can make more competitive offers on very favorable stable medical conditions, with the appropriate MD referral.