Avoiding Early Cancer Claims

Presentation #1

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Thanks to CRL and Milliman Intelliscript for Cosponsoring this Seminar!

IntelliScript

Early Cancer Claims

What are the 6 Causes?

- The ***applicant*** was not told he had CANCER
- The ***applicant*** lied, either by not disclosing the history…or framing it in misleading (but often technically truthful) terms such as *“mole removed, no further treatment”*
- The ***attending physician*** missed clues based on new symptoms, lab testing, etc. and made either no diagnosis or the wrong one

- An ***incidentaloma*** was never clinically worked up
- The ***underwriter*** missed clues on current lab testing, teleinterview and/or APS or failed to correlate them with the history such as a prior cancer
- No one knew (or probably could have known) that cancer was present…or that short-term risk was high at the time of the application

Bottom Line: incidental nondisclosure, which is distinct from intentional nondisclosure (lying), is not uncommon in cancer cases and manifests via several of the previously cited mechanisms

Our industry has done a poor job of distinguishing material incidental vs. intentional nondisclosure…and the result has been far too many contested death claims.

Or, is the problem a top management mandate to contest all death claims within 2 years regardless of the legitimacy of doing so?

My experience supports the alternative explanation.

Many physicians are changing what they tell some cancer patients.

Instead of “cancer” they are using “less psychologically traumatizing” terms.

We have seen this at the diagnosis of myelodysplastic syndrome…*more on this later*

Dunn. British Medical Journal. 347(2013):f5328

Doctors Miss Cancer

In a 2013 study looking at missed diagnoses, primary and metastatic cancer taken together was the #1 missed diagnosis!

We have seen many cases where the **attending physician misses evidence** associated with having a malignancy or being at high risk for a near-term cancer diagnosis.

Such is the enigmatic nature of 21st century for-profit managed care.

Singh. JAMA Internal Medicine. 173,6(March 25,2013):418-425

A new study shows that patients believe they are cured even when the prognosis is poor.

Among those with **stage 4** lung and colorectal cancer, 57% and 80% respectively said that their surgery was “likely to be curative!”

Those who rated communication with their physicians as “optimal” were most likely to come away believing they were cured.

Why should they jeopardize access to insurance by bringing up a condition they “know is cured”? ☺

Kim. Cancer. 121(2015):3564-73

It is not rare for patients with undiscovered advanced cancers to appear well just a few months before they die.

There was an FALU in Toronto 20 years ago who went into hospital because of vague GI pains, was diagnosed with widespread colorectal cancer and lived one more week. He was a friend and I saw him 2 months before he died. He looked wonderful and was running every morning.

Some will be approved preferred and die of cancer within the ensuing 12-24 months, despite being intrepidly truthful on the application and exhibiting no conventional evidence of cancer.

For example…

21 year old man starting his career applies for $250,000

- Runs 3-5 miles daily and competes in sports
- BMI and BP ideal
- Recent history of back pain, with normal x-rays
- Seen for nonspecific fatigue and gynecomastia; Rx muscle relaxants and told to avoid workout supplements. Did not use steroids.

This man will get "best preferred" from every company!

2 months later he was diagnosed with metastatic choriocarcinoma involving lungs and liver.

Pallais. New England Journal of Medicine. 373,24(December 10,2015):2358-69

Cigarette Smoking and Early Cancer Claims

- The critical issue is pack-years; not current smoking
- Insurers do not use pack-years but this can be ascertained from the APS in a minority of cases
- 40 PY is my (liberal) cutoff for never getting back to non-smoker cancer risk status or justifying consideration for nonsmoker rates after 1-5 years abstinence
- Being a long-time current or ex-smoker is a **RED FLAG** to be considered in context with other risk factors, especially low/underweight BMI, low/falling cholesterol and other markers we will discuss

RED FLAG

Recent Older Quitter

- Smokers > age 50 quit for different reasons than younger smokers
- 2 leading reasons: new serious diagnosis or scary symptoms
- #1 new diagnosis is cancer
- Comorbid recent-onset, first-time diagnosis of generalized anxiety disorder (GAD) is a RED FLAG in this context

Consider a PP interval for very recent quitters depending on context and especially if smoking for 35-40+ years?

Whitson. Journal of the American Geriatric Society. 54(2006):466

Huge **RED FLAG** Smoking Scenario

First 12 months after discharge following hospitalization for community-acquired pneumonia

381 Cases Involving Heavy Smokers

- No cancer diagnoses during hospitalization
- 8.14% diagnosed with lung cancer over the ensuing 12 months
- No significant markers for increased risk except long smoking history
- In another study, the median interval from discharge to lung cancer diagnosis was 109 days.
- There are 1.1 million annual hospitalizations for CAP every year

What's in your manual?

Shepshelovich. American Journal of Medicine. 129(2016):332

Tang. Archives of Internal Medicine. 171(2011):1193

An analogous scenario for new lung cancers occurs in patients treated at home for non-responding lower respiratory tract infections

After excluding community-acquired pneumonia, there is still a notable risk of undiscovered lung cancers emerging over the ensuing 12 months, primarily in longtime heavy smokers

Chalmers. British Medical Journal. 343(2011):d5840

X-ray/CT scan lung cancer screening programs are increasing because of "acceptable yields" of undiagnosed lung cancer.

- These are done primarily in longtime heavy smokers with a minimum pack-year count
- The most common suspicious finding is a pulmonary nodule
- 20-30% of patients diagnosed with invasive lung cancer will be identified on the basis of an incidentally discovered – for example, on cardiac CT scan for CAD - pulmonary nodule

What are the criteria for always deferring coverage in recently discovered incidental pulmonary nodules?

- ≥ age 70 + ≥ 40 pack years
- ≥ 2 cm non-calcified nodule
- ≥ 1 cm + doubling in size in 12 months
- Upper lobe lesion
- Irregular/spiculated (vs. smooth) borders

plus…

- Comorbid COPD
- Present on PET scan
- Discovered due to unexplained hemoptysis
- Chronic hoarseness/dry cough without diagnostic assessment
- Horner syndrome (ptosis, lack of sweating)

Incidental Chest-Area Cancer Findings

- Prevalence ranges from 0.8% to 7% on various scans, most reliable being PET
- In 59 cases of incidental suspected malignancy on CT scans, only 34 were further investigated!

Bottom line: if we want to find incidental cancer clues, we have to read scan reports on the APS!

Other **RED FLAGS**

- Incidentally discovered pleural thickening on chest area CT scan
- Digital clubbing
- Serum potassium > 5.1
- Solitary “rhonchus in the bronchus”