



Looking Back - Critical Thinking To Prevent Early Claims

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Elyssa Del Valle, M.D
Vicki Garrett moderating

Case #1 35-year-old male construction worker for 1 mil Whole Life and 300K CI

Application

Moved to Canada 2 yrs ago. NO PCP.

Questionnaire Part 2: Responded **NO** to all questions except **YES** to question #7.

Question #7. In the last 12 months, has the proposed insured had a change in weight greater than 10 pounds? Answer: He noted 15-pound weight gain due to diet and exercise and body building

RX neg MVR OK NO APS

Paramed:

5'11" 227lbs BP average of 3: 145/87

BUN 22 creatinine 1.6 Albumin 3.7 AST 35 ALT 40 Chol 285 HDL 42 Trigs 185 A1C 5.6% HOS: P/C 220 mg/g

UW decision:

Serum creatinine slight elevation likely due to increased muscle mass. 150% for build, lipids and blood pressure.

What transpired on this healthy
35-year-old male?

The Claim

- 10 months after policy issued
- Critical Illness Claim for kidney failure with symptoms one month after date of diagnosis

Claim Investigation

- Provincial health records obtained
- Validity of the policy was confirmed
- Hospital records
 - insured disclosed 2-week history of injecting steroids to assist with body building
 - presented with anasarca BP 175/110
 - BUN 55 Creatinine 3.2 Serum Albumin 3.4 Urine 3+ protein
 - renal ultrasound report – atrophic kidneys

Does insured meet the CI definition?

- Insured was started on dialysis 3 times a week three weeks after discharge
- He is awaiting a kidney transplant.

Kidney Failure is defined as a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of Kidney Failure must be made by a Specialist.

Exclusion

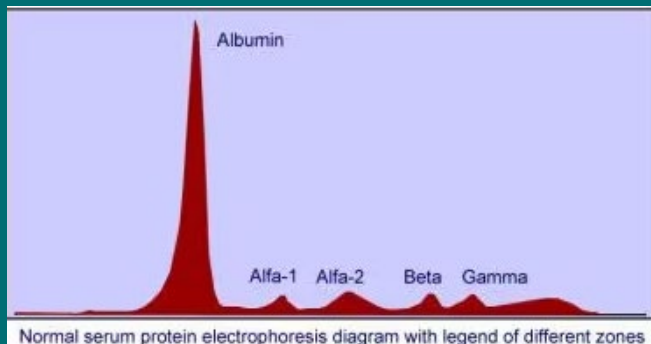
- There is an exclusion for any critical illness that results **directly or indirectly** from taking anabolic steroids.

Healthy kidneys should only filter tiny (trace) amounts into the urine as most protein molecules are too large for the glomeruli to filter.

Most common protein is **albumin** and small amounts can be seen in healthy subjects.

Larger amounts signify the following:

- increased glomerular permeability to large molecular weight proteins – glomerular disease
- incomplete tubular absorption – renal tubular disease



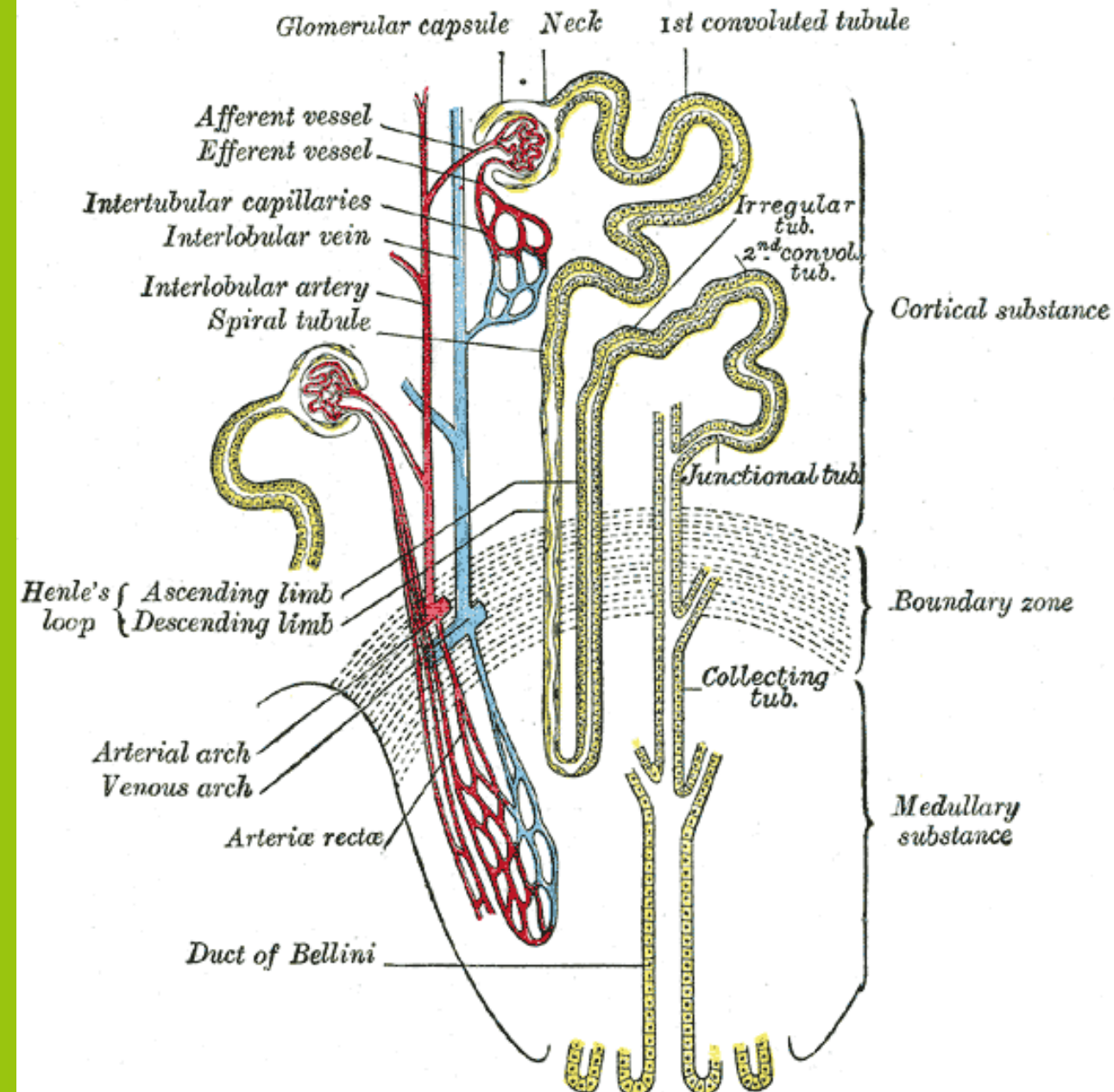
What is Proteinuria or Microalbuminuria



Proteinuria

Primary concern is leakage of protein from the blood into the urine due to damaged nephrons

- There are many diseases which cause damage to the nephrons
 - **Hypertension** and **diabetes** usually cause small amounts of proteinuria
 - **Glomerular diseases** can cause massive proteinuria



Nephrotic Syndrome as Depicted in this Claimant

Characterized by:

- Generalized Edema (anasarca)
- Hypoalbuminemia
- Massive proteinuria > 3.5 gms/day
- Hyperlipidemia
- Waxy casts and oval fat bodies in urine

Most common causes:

Primary renal (glomerulonephritis)

Systemic/extrarenal causes

- Diabetes
- HTN
- Amyloidosis
- SLE (lupus nephritis)
- Malaria

Drugs 

- Heroin, cocaine, amphetamines
- Anabolic steroid

Acute tubular necrosis associated with androgenic steroids and nutritional supplements in body builders

- Ingesting massive amounts of protein including protein supplements increases renal blood flow. Adaptive response to nitrogenous waste from byproduct of protein metabolism is filtration.
- Chronic hyperfiltration accelerates progression to glomerular damage.
- Because serum creatinine level is influenced by the amount of muscle mass, kidney dysfunction can be difficult to identify in highly muscular athletes.

chronic kidney disease will first present with proteinuria

Back to the Claim: Any red flags when Looking Back?

Paramed:

5'11" 227lbs BP average of 3: **145/87**

BUN 22 creatinine **1.6** Albumin **3.7** AST 35 ALT 40 Chol **285** HDL 42 Trigs 185 A1C 5.6% HOS: **P/C**
220 mg/g

Disclosed upon underwriting - weight gain of 15 pounds due to diet, exercise and body building

UW decision: 150% for build, lipids and blood pressure

- Hospital records
 - insured disclosed **2-week** history of **injecting anabolic steroids to assist with weightlifting**
 - **presented with anasarca** BP 175/110
 - **BUN 55 Creatinine 3.2 Serum Albumin 3.4 Urine 3+ protein**
 - renal ultrasound report – **atrophic kidneys**

Discussion

- Did this end stage kidney failure result directly or indirectly from taking anabolics?
- Kidneys were **atrophic** – Does that go along with an **acute** process/disease?
- Is the medical picture in keeping with the reported use of steroids for only 2 weeks?

Case #2 40-year-old businesswoman applying for 1.5 M whole life policy

- Application questionnaire: Last office visit 1 year ago for routine medical. Note indicated no concerns, blood sugar high normal and given mother has DM, she was advised to watch diet.
- Admits 1, occasionally 2 glasses wine most days; occasionally will have 2 cocktails on girl's night out
- MVR remote DUI 18 years ago when age 22. RX neg, APS not requested
- 5.7.220, 125/72, T Chol 220, HDL 75, Trigs 165, LFTs - AST 68, ALT 41, Albumin 3.6, A1C 6.0 , HOS neg for proteinuria

UW decision: Small rating due to build and A1C – 150%

What transpired on this
apparently healthy 40-year-old ?

The Claim

- Insured **died** of liver cirrhosis 1.5 years after the policy was issued

Claim Investigation

- health records obtained
- No alcohol criticisms until post-issue

Women are increasingly at risk
for alcohol-related liver disease.

Let's explore why.

Seems a whole new culture began since that HBO series aired in the 90s



Setting the stage on alcohol use among women

- Half of adult women report drinking alcohol.
- 13% adult women report binge drinking and on average 4/month consuming 5 drinks per binge
- 18% of women 18-44 binge drink
- In 2019, 32% of female high school students consumed alcohol compared to 26% of male counterparts and binge drinking 15% as compared to 13% of high school students.
- In 2019, 4% of women overall and 8% of those age 18-25 had an alcohol use disorder.

Per CDC





Statistics
Canada

Statistique
Canada



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⚡ In the news

★ Indicators

📁 Releases by subject

🔗 Special interest

📅 Release schedule

ℹ Information

Control and sale of alcoholic beverages, April 1, 2020 to March 31, 2021

[Text](#) [Tables](#) [Related information](#) [Previous release](#) [PDF \(245 KB\)](#)

Released: 2022-02-15

Alcohol sales increase despite
COVID-19 pandemic-related restrictions and
closures

Economist: Liquor store sales up 28% during pandemic; bars down 33%

by **Roby Brock** (robby@talkbusiness.net) 🕒 January 31, 2021 1:13 pm 👁 1,106 views



health

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HAPPENING NOW

Russia launches a large-scale attack on Ukraine. Watch CNN's live coverage and analysis of the invasion

We really did buy more alcohol during the early pandemic, study finds

By Sandee LaMotte, CNN

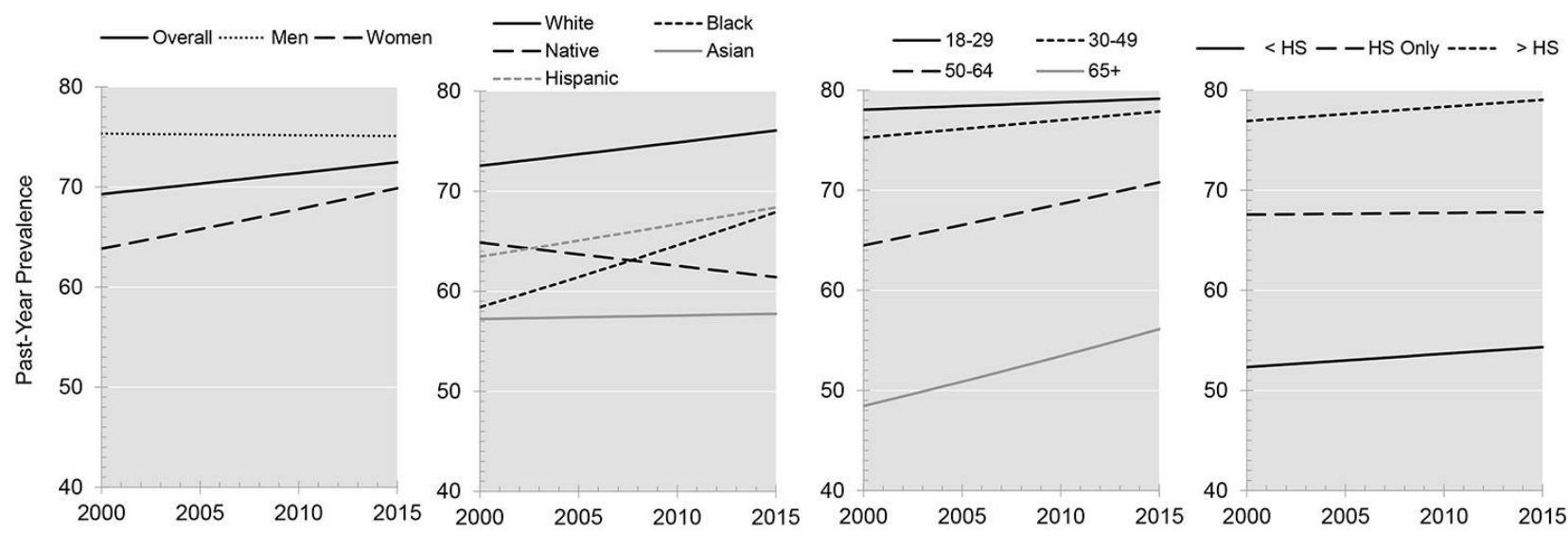
🕒 Updated 3:15 PM ET, Wed December 15, 2021



Swiss Re

More Data to Sound an Alarm

Trends in Adult Alcohol Use and Binge Drinking
in the Early 21st Century United States: A
Meta-Analysis of Six National Survey Series



Conclusion: Number of women 18 and older who drink each year rose by 0.6% each year as well as number of women who binge drink. Gaps in alcohol related harm between men and women is narrowing – A Cause for **ALARM**

Make no mistake; Alcohol deaths continue to be greater in men than women – women just catching up... in a bad way

Nov 1, 2022 Estimated Deaths Attributable to Excessive Alcohol Use Among US Adults Aged 20 to 64 Years, 2015-2019

Marissa Esser, PhD,
Gregory Leung, PhD,
Adam Sherk, PhD et al
Jama Network Open

The New York Times

Alcohol Deaths Claim Lives of Working-Age Americans

A C.D.C. study estimates that, over five years, one in eight deaths of people ages 20 to 64 occurred because of alcohol-related injuries or illness.

 Give this article



A few stark conclusions

- Largest increase in alcoholic liver disease is in women ages 25-34
- Typically takes 10 or more years of drinking to develop liver disease, thus a concern if seeing premature mortality from liver disease in ages under 35
- Women dying from ALD 2-3 years earlier than men
- Alcoholic liver disease is a leading indication for liver transplantation which was stable for over 3 decades until now

Why are women more susceptible?

What makes women more susceptible to adverse affects of alcohol?

- Higher levels of endotoxins from gut bacteria after single episode of binge drinking
- Alcohol boosts the permeability of gut endotoxins and bacteria to enter bloodstream
- Rise in alcohol misuse – girl's night out – self medicating stress
- Theory that women have less water in their bodies than men (smaller volume of distribution) with subsequent higher BAC
- Women absorb more alcohol taking longer to metabolize it thus, the immediate affects occur more quickly and last longer
- Estrogen activates Kupffer cells leading to cytokine release and inflammation
- Women have lower levels of cytochrome P4502E1, important for ETOH metabolism

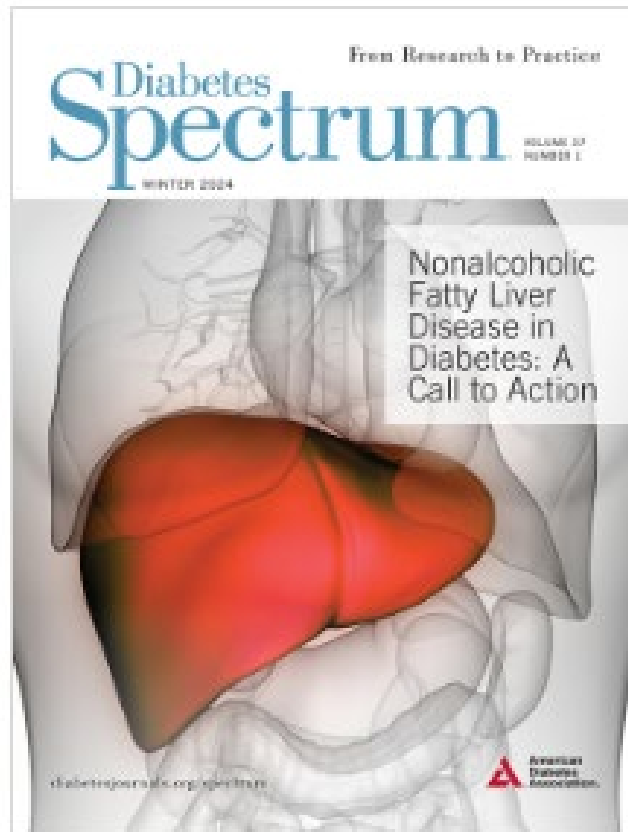
Cocktails and now the COVID 19 POUNDS

This claimant likely had fatty liver - which we now named Metabolic associated steatotic liver disease

And the forgotten, overlooked condition

Volume 37, Issue 1

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Metabolic dysfunction-associated steatotic liver disease: A silent pandemic

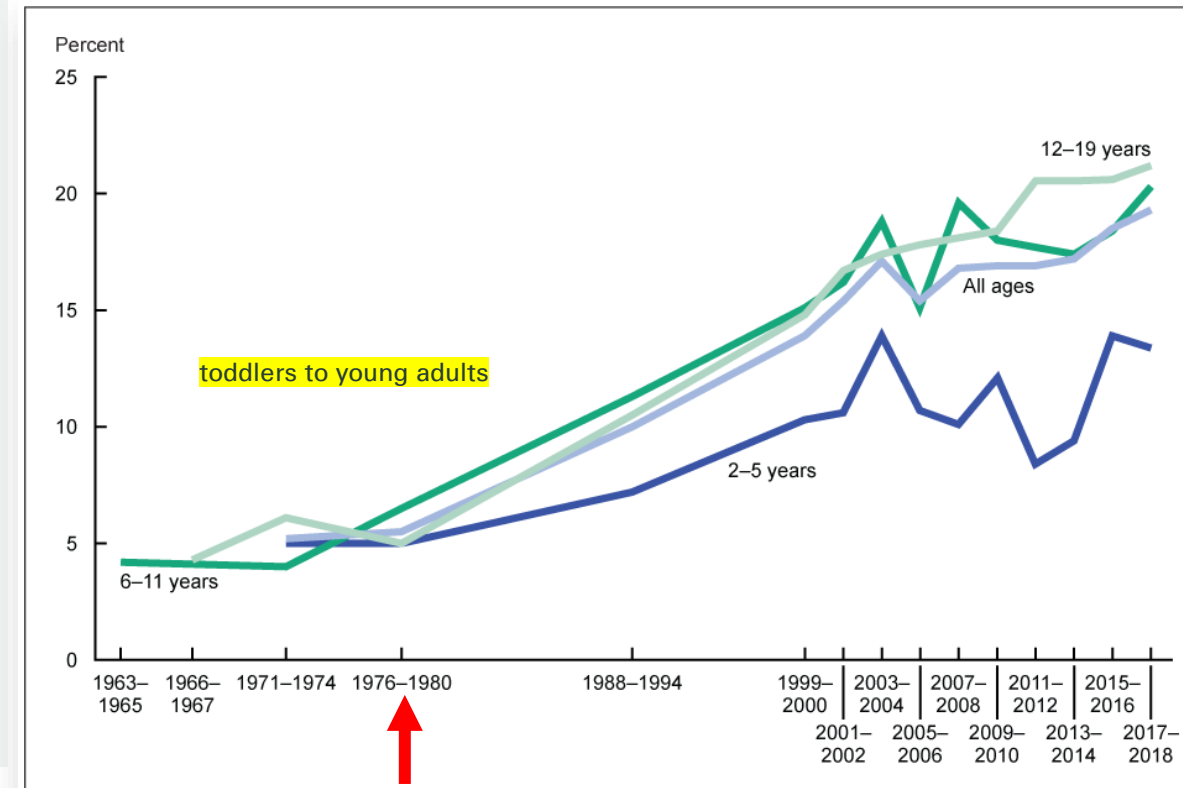
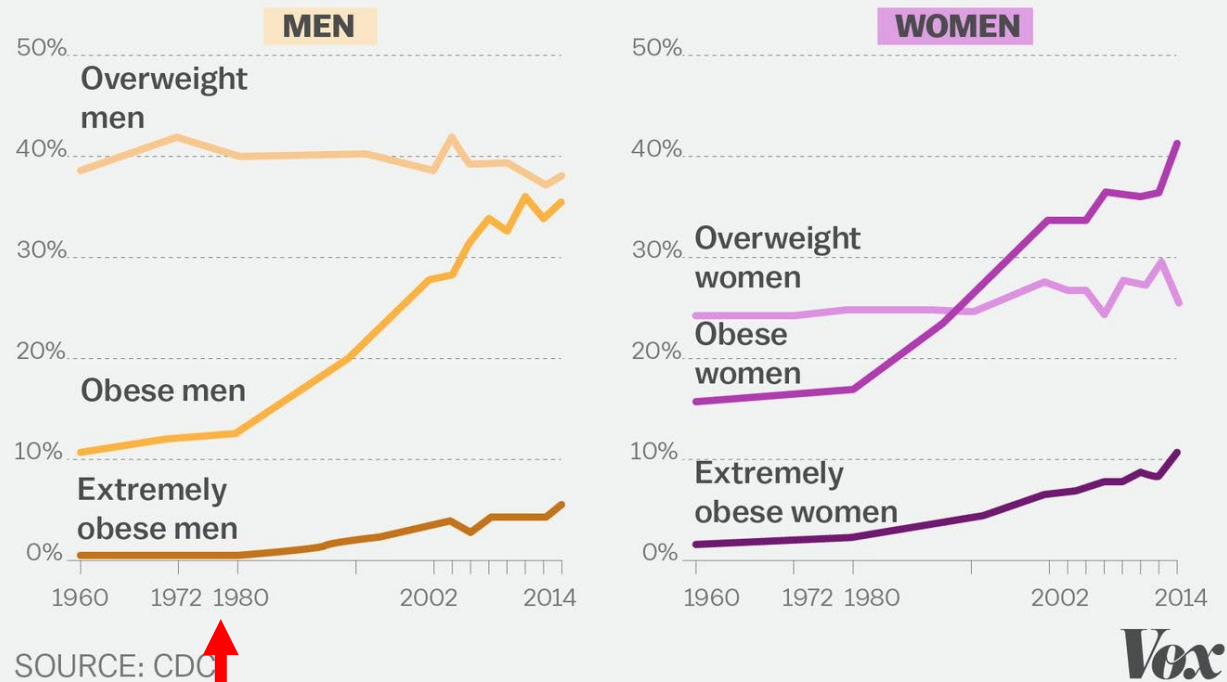
[Arghya Samanta](#)¹, [Moinak Sen Sarma](#)²

Emerging trends and hotspots in metabolic dysfunction-associated fatty liver disease (MAFLD) research from 2012 to 2021: A bibliometric analysis



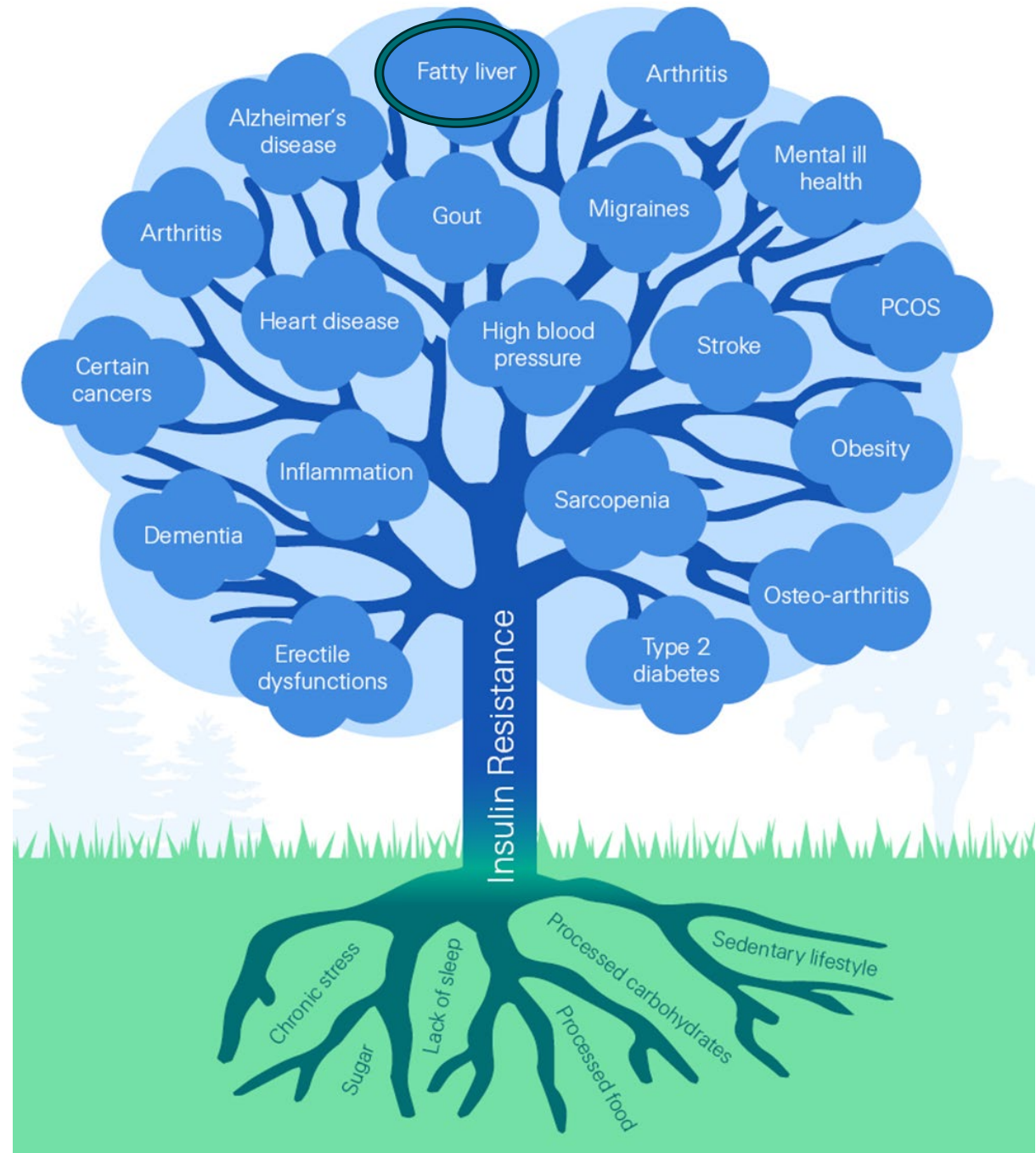


The stunning rise of obesity in America

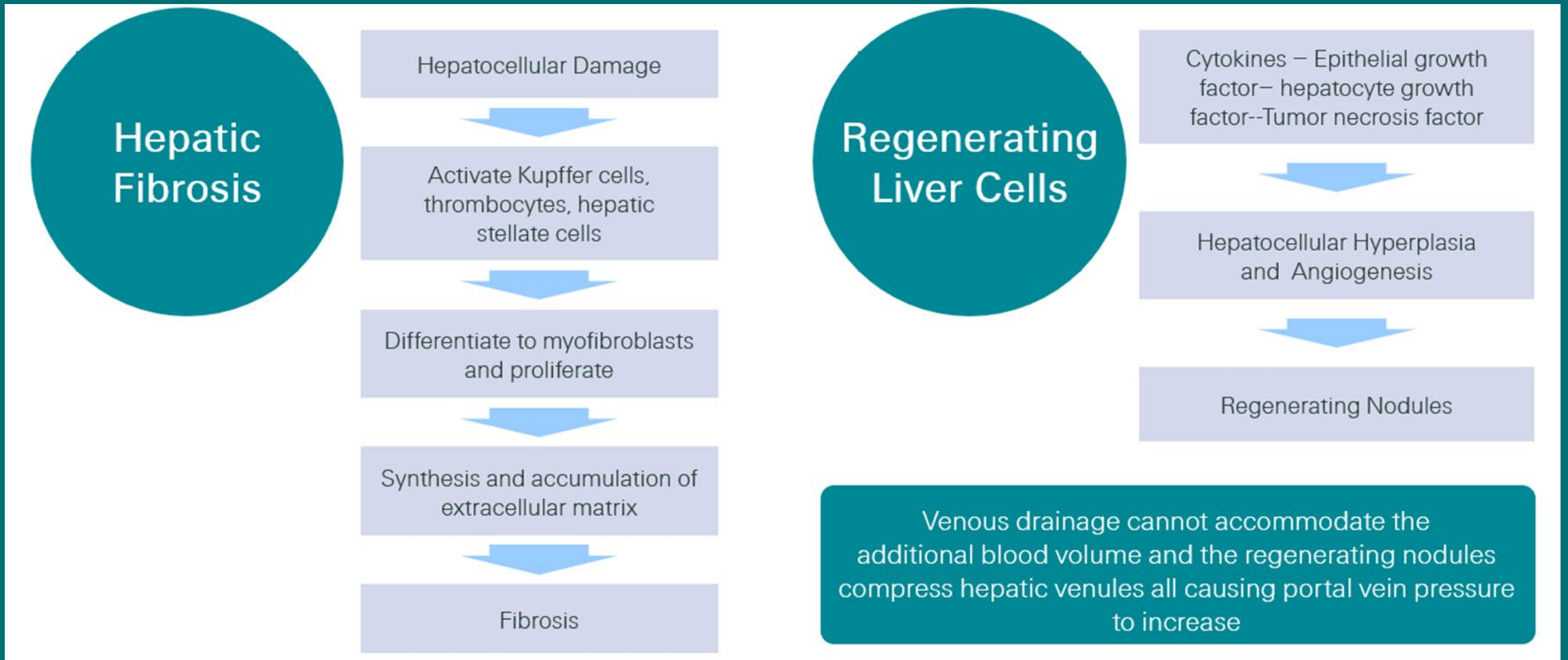


NOTE: Obesity is body mass index (BMI) at or above the 95th percentile from the sex-specific BMI-for-age 2000 CDC Growth Charts.
SOURCES: National Center for Health Statistics, National Health Examination Surveys II (ages 6–11), III (ages 12–17); and National Health and Nutrition Examination Surveys (NHANES) I–III, and NHANES 1999–2000, 2001–2002, 2003–2004, 2005–2006, 2007–2008, 2009–2010, 2011–2012, 2013–2014, 2015–2016, and 2017–2018.

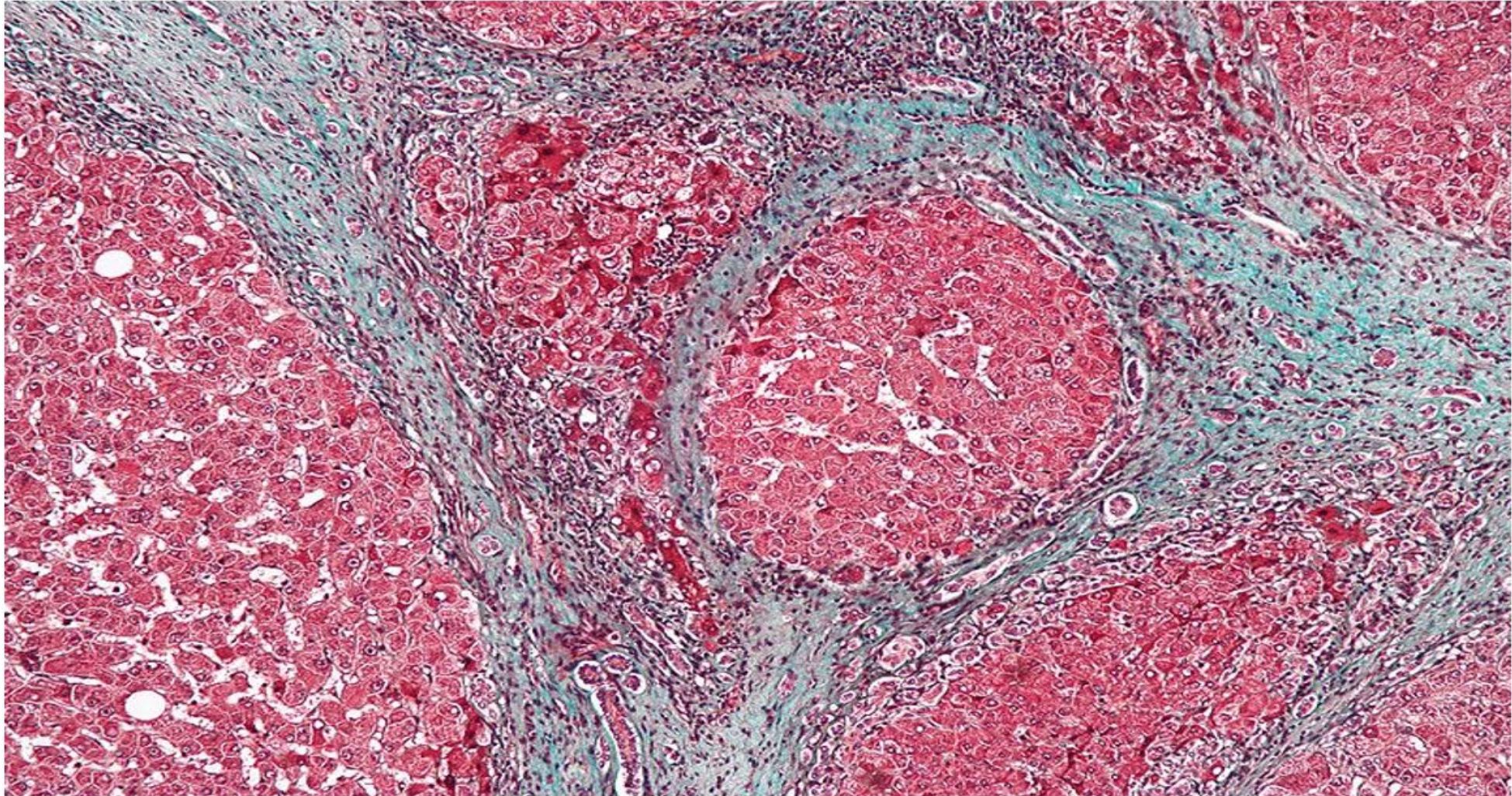
Conditions associated with Insulin Resistance



How does fat and alcohol turn a healthy liver into a cirrhotic liver?



Histology of Liver Cirrhosis



Liver Cirrhosis: Complications



No way to reverse these late stages of Cirrhosis Decompensation
Only treatment at late stage is Liver Transplantation

Back to our 40-yr old businesswoman

Is the policy valid?

- Can this policy be rescinded due to nondisclosure due to binge drinking?

Any missed red flags??

Last office visit 1 year ago for medical, no concerns, blood sugar high normal, FHx mom DM 65, advised to watch diet

- Admits 10 drinks per week; remote DUI 18 years ago
- Paramed labs: T Chol 220, HDL 75, Trigs 165, LFTs - AST 68, ALT 41, Albumin 3.6, A1C 6.0, HOS neg for proteinuria
- Upon further review of that 1 yr ago visit at her PCP's
 - LFTs - AST 77, ALT 52, Albumin 3.6, A1C 6.2
 - CBC MCV 110, Platelets 125,000 HDL 95

Let's do another claim

Case #3 48-year-old male smoker for 1 million WL Insurance advisor

- Permanent resident in USA for 3 years at time of application
- Past travel to Vietnam but none since the pandemic, no current plans
- Declared mild abdominal pain, indigestion early 2021, no other history declared
- Last office visit 1 yr ago for meet and greet new MD, had check up, including labs

Paramed:

5'9" 155 lbs 125/75 A1C 5.8, Chol 185, HDL 43, LFTs: AST 45, ALT 22, Albumin 3.7, HOS + cotinine

MVR, Rx unremarkable

UW Decision: STD smoker

What transpired on this 48-year-old male insurance advisor?

The Claim

- Insured died in Vietnam from post-liver transplant complications 2 years after the policy was issued
- According to the medical proof of death, the insured's first symptoms were 2 months after the issue date. Symptom was hematemesis (vomiting blood)

Claim Investigation

Health records requested

- diagnosis of Hep B from labs at meet and greet
- referral to hepatologist – no further records

Foreign death claim investigation

- Insured diagnosed with chronic active hepatitis B in Vietnam 2 years prior to death
- Liver transplant undergone 1 year after application issuance
- He died from complications
- Policy and claim determined to be valid

Top liver conditions in developed countries

- Alcoholic liver disease
- Chronic viral hepatitis (B and C) – increase in Hep C related to IV heroin on rise
- Hemochromatosis (iron overload)
- Nonalcoholic fatty disease (NAFLD)

Less common causes:

- Autoimmune hepatitis, primary and secondary biliary cirrhosis, primary sclerosing cholangitis, Wilson, alpha 1 antitrypsin deficiency, celiac, granulomatous liver disease, polycystic liver disease, infection (brucellosis, syphilis, echinococcosis), right heart failure, Osler Weber, veno-occlusive disease

Top liver conditions in developing countries

- Highest burden is Hepatitis B via vertical transmission (mother to child)
- Hepatitis E especially in Africa and Asia from contaminated waters
- Concomitant HIV with or without Hep B or C
- Alcoholism
- Aflatoxin (carcinogen) specially in sub-Saharan Africa and China
- Liver cancer is most common cause of cancer in men in 11 developing countries: Mongolia, Gambia, Thailand, South Korea, Taiwan, North Korea, Guinea, Mali, Cameroon, Tonga, and Guinea-Bissau (in order of most to least)
- Liver flukes-Clonorchiasis – high association with cholangiocarcinoma
- Also seeing more and more Fatty Liver as obesity is a global problem

Prevalence of Hepatitis B

- Estimated 350 million worldwide have Chronic Hep B
- 2 billion are infected at some point in their life
- Most prevalent in Western Pacific and Africa in which 6% of population infected; Southeast Asia, Taiwan, Sub-Saharan Africa and the Amazon basin with prevalence up to 60%; rates falling with increased Hep B vaccination
- Those at risk for **chronic** disease: depends mostly on age at which infected
 - In infants and children: 80-90% of infants infected during the first year of life
 - 30-50% of children infected before age 6
 - In adults: Less than 5% of otherwise healthy persons infected

Concern is 20-30% of adults with chronic Hep B will develop cirrhosis and/or liver cancer

Bad prognostics for Hepatitis B

- elevated ALT and AST suggests active disease
- elevated viral load
- Hepatitis Be Antigen positive
- Family history
- Serotype C
- Male gender
- Smoker

Discussion - Back to the 48 yr old male

- Policy issued without obtaining the lab results from that meet and greet when establishing with new doctor
- Policy issued without obtaining any medical from Vietnam

What did the labs reveal from Meet and Greet

- LFTs AST **135**, ALT **155**, Albumin **3.7** CBC with Platelets **155K**
- Reflex **HBSAg positive** and Hepatitis **BeAg positive** and **HBSAb negative** Hep C Ab negative

Referred to hepatologist

Looking back at time of Underwriting on this 48 year old smoker

- Permanent resident in USA for 3 years at time of application Country of birth: Vietnam
- Declared mild **abdominal pain**, indigestion early 2021, no other history declared
- Last office visit **1 yr ago for meet and greet new MD, had check up, including labs**

Paramed:

5'9" 155 lbs 125/75 A1C 5.8, Chol 185, HDL 43, LFTs: **AST 45, ALT 22**, Albumin **3.6**, HOS + cotinine

MVR, RX unremarkable

ANY QUESTIONS?



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