

The Decision



with **Karen Orozco**, AVP & Chief Underwriter

The Underwriting Tool Kit – Mammography and Colonoscopy

Have you noticed in the media that it seems like the rates for breast and colon cancers are increasing? They are. But one reason for the increased incidence is that we have better ways of detecting these diseases. By the time they're 40, many of your clients are being screened for these and other cancers.

Screening tests – like mammography and colonoscopy – are more common in underwriting and we now consider them part of our underwriting “tool kit.” So just how does an underwriter use the information to make a decision about your client?

Background

Each province developed guidelines for screening patients for breast and colorectal cancer, two of the leading types of cancer deaths in the Canadian population. By screening clients at risk of these diseases, governments and doctors hope to reduce the death rates.

According to the Canadian Cancer Society website:

- Each week, 400 Canadians are diagnosed with colorectal cancer and 167 will die of it
- Each week, 429 Canadian women are diagnosed with breast cancer and 102 will die of it
- In 2007, 170 (est.) men will be diagnosed with breast cancer and 50 will die of it
- One in 9 women will develop breast cancer during her lifetime and one in 27 will die of it

Underwriting the Risk

With the introduction of screening guidelines, underwriters are presented with more information about your clients than in the past. The challenge comes in determining when we absolutely have to see the results of the investigation and when we can issue a policy without the test having been completed. This gets complicated by the waiting times and lack of facilities for testing in certain regions in Canada.

Generally, if the tests are scheduled as part of a routine physical, with no symptoms prompting the investigation and no family history of cancer, they are of minimal consequence to the underwriting process. If the test, as part of a routine physical, is scheduled and has not yet been completed, we may not hold up issuing a life, critical illness or disability insurance policy. Your client must clearly state when applying for insurance that these tests are pending as part of the routine physical as well as when they expect the test to be completed. For large risks and depending on the age, if the test is to be completed in the next month or so, the underwriter may decide to wait until the test results are available simply because of the size of the case. While we understand this causes delays, from a risk management perspective it does not make sense to issue a large face amount without all the facts.

It is important to note that family history is a key consideration when screening is recommended. While family history is a key risk factor for life and critical illness underwriting, it has not yet been routinely factored into the disability risk assessment. As a result, family history is rarely a source of action for disability insurance, although it may impact the larger picture risk assessment.

The Decision

Here are examples of the impact these tests have on an underwriting decision.

Male 54, non-smoker. Applying for \$750,000 Life, \$500,000 Critical Illness or \$5,000/month Disability

- Routine physical May 2007, all results within normal limits.
- Given prescription for cholesterol lowering drug in May 2007.
- Advised to have screening colonoscopy because of age. Booked for next month, the earliest time the client can fit it into his schedule. No family history of colon cancer.

Life Decision – Accept without colonoscopy.

Disability Decision – Accept without colonoscopy.

Critical Illness Decision – Accept without colonoscopy. If a family member had colon cancer diagnosed prior to age 60, a 150% rating would be required. We could apply a 25% credit if there was a negative colonoscopy within 3 years of the application and the client is age 40 or over, for an overall rating of 125%.

Female 48, smoker. Applying for \$2,500,000 Life, \$250,000 Critical Illness or \$5,000/month Disability

- Routine physical June 2007, all results within normal limits.
- Advised to quit smoking and have a screening mammogram. Last mammogram was at age 42 and was normal.
- Mother died two years ago at age 75 of breast cancer.

Life Decision – Wait for mammogram results before proceeding. Assuming normal mammogram results, she'll be a standard Healthstyle 5.

Disability Decision – Wait for the mammogram, assuming normal results, standard.

Critical Illness Decision – Wait for the mammogram results, assuming normal results, standard.

Male 39, non-smoker. Applying for \$1,000,000 Life, \$500,000 Critical Illness or \$5,000/month Disability

- Last saw his attending physician in 2002 for a cold.
- Father died at age 45 of colon cancer, sister age 47 treated for colon cancer. Mother and brother alive and well.

The Decision – Postpone and reconsider with current physical exam to include colonoscopy. According to the Manulife Underwriting Manual, this client has a 15% greater chance of having colon cancer than those with no family history. In addition, the cancer screening recommendation for this client is to begin screening at an age 10 years before the earliest age at onset of the first degree relative with colon cancer. In this case, screening should have begun at age 35.

Life Decision – Assuming a negative colonoscopy, he would be rated 150% due to the strong family history and his age. This rating would be reconsidered after age 55.

Critical Illness Decision – Same concerns as Life. Rateable 175% for 2 family members diagnosed with colon cancer prior to age 60. With a negative colonoscopy within 3 years, will have a 25% credit for a total rating of 150% for critical illness.

Disability Decision – Assuming a negative colonoscopy, standard.

Female 42, non-smoker. Applying for \$500,000 Life, \$200,000 Critical Illness or \$5,000/month Disability

- Routine physical in June 2007. Advised to have screening mammogram, not yet booked.
- No family history of breast cancer, mother, father and 3 sisters all alive and well.
- No other risk factors.

Life Decision – Accept standard.

Critical Illness Decision – Accept standard.

Disability Decision – Accept standard.

Male 45, smoker. Applying for \$250,000 Life, \$75,000 Critical Illness or \$3000/month Disability

- Mother died age 62 colon cancer.
- Routine physical May 2007, colonoscopy recommended in view of family history and recent episode of rectal bleeding.

Life Decision – Postpone until colonoscopy completed. Note: greater concern is the current rectal bleed, not the family history at age 62.

Critical Illness Decision – Postpone until colonoscopy completed. Note: greater concern is the current rectal bleed, not the family history at age 62.

Disability Decision – Postpone until colonoscopy completed.

These cases are examples only. Not every case is straightforward and the underwriting outcome will be different in many cases since it depends on the risk factors presented, the type of insurance being requested and the face amount applied for.

As you'll read in the next section, our provincial governments are providing various levels of funding for screening programs. This, and the increased awareness of the general population for the need to screen for disease, means we may begin to use routine cancer screening as a credit when underwriting proposed insureds for coverage.

By Karen Orozco, Chief Underwriter, Individual Insurance

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A Detailed Look at Screening Guidelines for Colorectal Cancer and Breast Cancer

By Dr. Lorne Wilson, BSc., MD

What is a screening test?

It's a way to sort out apparently well people who probably have disease from those who probably don't, according to the *Dictionary of Epidemiology*. Once the screening is done, people who are screened as "positive" or who have suspicious findings are referred to their physicians for diagnosis and treatment.

Screening guidelines have been created by government and non-governmental organizations, health agencies and professional associations. So, the guidelines vary within Canada and within individual provinces, depending on the source.

Colorectal Cancer

Did you know that colorectal cancer (CRC) is the second leading cause of death in Canadian men and women, yet it is one of the most preventable cancers? In fact, Ontario has one of the highest rates of CRC in the world.

The good news is that there is a 90% chance of curing CRC if it is detected early. The bad news is that the chance of curing it will fall to only 10% if it is detected at an advanced stage. That's why CRC screening is critical. Because Ontario has such high rates and because screening is so important, the Ontario government recently announced a \$193.5 million CRC screening program to be instituted over the next five years.

Screening methods for CRC may include all or some of the following:

- Digital rectal exam
- Barium enema
- Sigmoidoscopy
- Fecal occult blood test (FOBT)
- Colonoscopy.

The Canadian Cancer Society, the Canadian Task Force on Preventative Health Care Health Canada, the Canadian Association of Gastroenterology and Cancer Care Ontario recommend that all people aged 50 years and older who are of average risk with no symptoms and no family history of the disease should be screened for colorectal cancer with FOBT. The British Columbia Cancer Agency agrees the rationale for FOBT is strong, but leaves it to the discretion of the physician. The initial screening for CRC is a FOBT carried out every one or two years. If the test is positive, then a follow up colonoscopy will be arranged.

Individuals with a family history of colorectal cancer are at an increased risk and should speak to their primary care provider. They will generally be directed to receive a colonoscopy. If the individual has no polyps, then they would receive a reminder for a colonoscopy every 10 years. If polyps are present and removed, they would receive further colonoscopies every five years.

The British Columbia Cancer Agency also considers the use of flexible sigmoidoscopy for those at increased risk (i.e. first-degree relatives with colorectal cancer, history of breast, ovarian or endometrial cancer) and colonoscopy for those at higher risk (i.e. colorectal cancer history, polyp history, ulcerative colitis of 10+ years duration and total colonic involvement, relatives with familial polyposis).

The BC Medical Journal (Volume 42, April 2000) states that sigmoidoscopy and double contrast barium enema are probably acceptable if colonoscopy is not available, although there is no definite evidence to support this belief.

And according to the same issue of the BC Medical Journal, there are many ways to investigate colon cancer following a positive FOBT:

- A rectal exam will detect fewer than 10% of colorectal cancers
- Rigid sigmoidoscopy will detect up to 20% of colorectal neoplasms
- Flexible sigmoidoscopy will detect up to 66% of colonic neoplasms if a complete exam is done
- Double contrast barium enema has a sensitivity of 50% to 80% for polyps <1 cm and 70% to 90% for polyps >1 cm, but the test has never been validated as a screening tool.
- Colonoscopy offers the greatest accuracy and combines the ability to visualize the entire colon with the potential to biopsy and possibly remove neoplastic changes.

Colonoscopy remains the only validated investigative technique following a positive screening test and FOBT has been the only method of CRC screening that has been proven, in controlled trials, to reduce death from CRC.

Breast Cancer

Breast cancer is the most common type of cancer for women and the risk of being diagnosed with the disease increases as the woman ages. At least 80% of breast cancers are found in women over the age of 50. And, despite popular myth, at least 80% of women diagnosed with breast cancer have no family history. About one in nine women who live to be 90 will be eventually diagnosed with breast cancer.

There are three screening tests for breast cancer: the breast self exam (BSE), screening (breast exam) by a trained health care provider and mammograms. With early detection there is a greater chance of successful treatment and there are more treatment options available.

All women over 20 should receive an annual physical exam of their breasts by their family physician, both as a screening procedure and as an opportunity to teach breast self exam. Self exams are important because 10% of breast cancers won't show up on mammogram in older women and as many as 25-30% of breast cancers are not seen on mammograms in women age 40-49.

In general, women under the age of 40, unless they fall into the high risk group, are recommended to carry out SBE and annual clinical exams. Women with two or more first degree relatives with premenopausal or bilateral breast cancer are considered particularly high risk and should be referred for genetic counseling and assessment for hereditary cancer.

The Ontario Breast Screening Program (OBSP) and the Screening Mammography Program of B.C. (SMPBC) both indicate that there is no clear evidence to support the recommendation of annual breast screening mammography in women under the age of 40. However, both groups suggest women discuss the pros and cons of mammograms with their family doctor. SMPBC does encourage attendance at least every 24 months.

In women aged 50-69, the OBSP and SMPBC recommend screening mammograms every one to two years. The SMPBC extends this recommendation up to age 79. The OBSP indicates that mammograms are not universally recommended over the age of 69 years, but this may be considered after a discussion with their doctor or health care provider. The SMPBC has a similar statement for the 80+ age group and recommends that referral for screening exams are made by family physicians. The College des medecins du Quebec and the OBSP have issued identical guidelines.

Other methods of screening for non-palpable breast abnormalities include thermography, ultrasound and diaphanography, but in the screening of asymptomatic women none of these techniques approach the sensitivity or the specificity of mammography and cannot be recommended at the present time as the sole screening method. Ultrasound may be very useful, in conjunction with a mammogram, for diagnosis of breast lesions, and in that situation is part of the workup of the mass. There are studies looking at magnetic resonance imaging (MRI) in high risk women with identified genetic mutations to see if it can add to their screening. At this time there are no studies showing a survival benefit using MRI screening.

Overall, we expect to observe a reduction in mortality (death) and possibly in morbidity (sickness) with early cancer detection. This may suggest a cost savings. However, with increased screening there will be increased false positive testing that will lead to further testing and increased costs to the system. We will have to wait to see if screening turns out to be cost effective.

It's important to note that for these programs to be effective, there must be a comprehensive public awareness campaign and the testing must be easily accessible.

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