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# I'm getting old (and it's costing me)

**T**he inevitable consequences of aging finally hit me last year, at age 64. Before then, I was a (reasonably) healthy, active person. I exercised a little, ate reasonably healthy meals, and took no medications. My only visits to my doctor were for annual (sort of) exams. That all changed when I began to have neurogenic claudication in both legs. I had no history of back injury but, with worsening pain, I sought the opinion of my physician.

It turned out that I had a dynamic spondylolisthesis and disc herniation that could only be fixed with a single-level fusion. From a neurologic perspective, the procedure

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was an unequivocal success. However, my recovery (with lack of exercise) had the unintended “side effect” of a 25-pound weight gain. As a family doctor, I know that the best way to reverse this gain is by increasing my exercise. However, I also know that, at my age, many specialty organizations recommend a cardiac evaluation before beginning strenuous exercise.<sup>1</sup>

So, I set up a routine treadmill test. Although I exercised to a moderate level of intensity, the interpreting cardiologist was unwilling to call my test “totally normal” and recommended further evaluation. (One of the “unwritten rules” I’ve discovered during my career is that adverse outcomes are far more likely in medical personnel than in nonmedical personnel!)

He recommended undergoing coronary artery computed tomography angiography with coronary artery calcium (CAC) scoring. The result? A left anterior descending artery CAC score of 22, which placed me at a slightly increased risk of an adverse event over the next 10 years. (The benefit of exercise, however, far outweighed the risk.) I’m happy to report that I have lost five pounds with only mildly intensive exercise.

Along with facing the health aspects of aging, I am also faced with the economic realities. I have carried group term life insurance throughout my career. My 10-year term just happened to expire when I turned 65. I have always been insured as a “Tier 1” customer, meaning that I qualified for the best premiums due to my “healthy” status. That said, the transition to age 65 carries with it a significant premium increase.

Imagine my shock, though, when I was told that my premium would jump to MORE THAN 4 TIMES the previous premium for ONE-THIRD of my previous coverage! The culprit? The CAC score of 22!

It turns out that the insurance industry has adopted an underwriting standard that uses CAC—measured over a broad population, rather than a more age-confined one—to determine actuarial risk when rating life insurance policies.<sup>2</sup> As a result, my underwriting profile went all the way to “Tier 3.”

CONTINUED ON PAGE 243

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## GUEST EDITORIAL

CONTINUED FROM PAGE 219

We're used to medical consequences for tests that we order—whether a prostate biopsy for an elevated prostate-specific antigen test result, breast biopsy after abnormal mammogram, or a hemoglobin A1C test after an elevated fasting blood sugar. We can handle discussions with patients about potential diagnostic paths and readily include that information as part of shared decision-making with patients. Unfortunately, many entities are increasingly using medical information to make nonmedical decisions.

Using the CAC score to discuss the risk of adverse coronary events with my patients may be appropriate. In nonmedical settings,

however, this data may be incorrectly, unfairly, or dangerously applied to our patients. I've begun thinking about these nonmedical applications as part of the shared decision-making process with my patients. It's making these conversations more complicated, but life and life events for our patients take place far beyond the walls of our exam rooms. **JFP**

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