Life Insurance for Cancer Patients

The following article consists of exerpts taken from a panel discussion held on March 28, 1983 in Beverly Hills, California, sponsored by the Executive Life Insurance Co. The panelists were Dr. Arnold Benson, F.A.C.P., insurance consultant; Dr. Peter Rosen, F.A.C.P., Clinical Professor of Medicine at the University of Southern California, oncology consultant to Executive Life Insurance Co.; Dr. Leonardo Chait, F.A.C.P., Associate Professor at UCLA, and Medical Director of the Executive Life Insurance Co.

Dr. Benson: Would you consider a papillary tumor of the bladder a relatively benign situation?

Dr. Rosen: If it's low grade and not invasive. Bladder cancer is pretty well correlated with degree of anaplasia and degree of invasion. Some patients with papillary carcinomas of the bladder eventually, after many years, get into trouble. But the majority of problems occur in patients with high grade and invasive carcinomas. An unusual kind of bladder tumor is carcinoma in situ. It tends to be a multifocal carcinoma, a more malignant disease. There is a lot of controversy about what to do for those patients. If it is a multifocal change throughout the bladder a lot of urologists are becoming very concerned about early intervention and advocate cystectomy at a very early stage. You have picked a particularly complicated area when you talk about bladder cancer. The natural history is quite variable and prognosis is not very clear. Grade I papillary carcinoma of the bladder is a much better lesion than a carcinoma in situ of the bladder. So that's one of those areas in medicine which I think in the next few years is going to change because there is an evolution in thinking.

Dr. Chait: What about the seminomas that have positive lymphangiograms and are presumed to have metastatic lymph nodes in the abdomen and are treated with radiation therapy besides the orchiectomy. Do you think that even those are usually cured if there is no evidence of recurrence after two years?

Dr. Rosen: Yes, they should be very close to a standard rate.

Dr. Chait: What about non seminomas?

Dr. Rosen: Non seminomas treated with adequate chemotherapy now have a similar outlook. You must check the records very carefully because even in the U.S. there are areas where medical treatment is below standard. For example, if the treatment would not have included the use of platinum as one of the drugs, the risk of recurrence would be significantly higher. I cannot think of any other area in medicine where these issues are that critical.

Dr. Chait: You are right and not only the treatment but also the staging.

Dr. Benson: The general outlook is getting better. The updated statistics are looking much better than they were.

Dr. Rosen: Yes, but only for certain tumors. I think you'd be hard pressed to show improvement in lung cancer.

Dr. Chait: What areas do you think are not advancing?

Dr. Rosen: I think there's been no progress in colorectal cancer, except for one very peculiar statistical artifact, which I can't explain to you. It used to be that whenever you would see a patient with colon cancer who had regional lymph node metastasis at time of surgery, (stage III of Duke's classification), you'd assign an extremely poor prognosis. Today, and I don't think anybody has explained this satisfactorily, there is a higher survival rate, Duke's C colorectal cancer had a 25-35% 5/y survival but it is going up — inexplicable without any change in its treatment.

Dr. Chait: With Duke's C, which means regional lymph node metastasis, after how many years do you feel they are cured?

Dr. Rosen: I think that the so called five-year period is a reasonable period in colorectal cancer. That doesn't mean that there won't be a few straggling recurrences at six or seven years, but I think you're covering 90% of your recurrences within that 5/y period, and it's only the

rare patient that's going to recur after five years. There are other cancers where 5 years is an inadequate follow up. In breast cancer, for example, it is common to see recurrences at six, eight, ten, twelve or more years, even 20 years later.

Dr. Chait: How about prostate?

Dr. Rosen: Prostate I think is another tumor prone to show late recurrences. The difference with prostate is that you are dealing with an extremely elderly population where it's very hard to get long follow ups.

Dr. Chait: OK. Let's say onset at age sixty.

Dr. Rosen: Yes, but most of the cases do not have an onset at age sixty. The bulk of the data is prejudiced against those patients. I think late recurrences are going to be seen in prostate cancer — that's my strong feeling. They are not going to be seen commonly in colorectal cancer or lung cancer — again, that doesn't mean that they won't be seen.

Dr. Benson: What would you feel the percentage of late metastasis would be in breast cancer say eight, nine, ten years after treatment?

Dr. Rosen: I'd say 20-25%. That's the problem. And, of course, now we're altering the natural history of breast cancer by giving adjuvant therapy. Only time is going to tell how long that may push back recurrences. I don't know whether it's going to cure many people. Even the most intensive proponents of adjuvant chemotherapy don't really know because they haven't had long term studies. They believe they are going to cure more patients — they may be right — I just don't happen to know the answer. It may be that they're going to push back recurrences. Instead of the tumor recurring at six years, it may recur at eight years or nine years. If that's the case, we're going to see a lot more of late recurrences. The number of breast cancer patients being treated with chemotherapy up front is incredibly high right now — virtually every premenopausal patient with lymph node metastasis is now getting adjuvant chemotherapy. Many of the postmenopausals are getting it too. We are pretty sure that it's going to delay recurrence — the question is whether it is going to prevent recurrence and the difference between "delay" and "prevent" is a vast difference.

Dr. Chait: What about estrogen receptors, how significant do you think that's going to be?

Dr. Rosen: There are some studies that strongly correlate prognosis with estrogen receptors. Other studies are not nearly as convincing. In the premenopausal age group, I think it's going to be very difficult to use because the endogenous estrogen production of the patient may interfere with the assay. In other words, if there is enough circulating estrogen, it may bind to the breast cancer cells and you may get a false negative assay. See the problem . . .you may totally underestimate the percentage of women under the age 50, actively menstruating, who have positive estrogen receptors. I don't know what that's going to turn out to mean.

Dr. Chait: So they are more significant in the postmenopausal women?

Dr. Rosen: I suspect they are going to be because in them the assay will be correct, whereas in the premenopausal it may not be correct. I think a positive assay is meaningful — a negative one may not be meaningful in a premenopausal. The other question is how useful is this information, it has a definite prognostic relevance but the question is, to what degree. In some of the studies it seems to be as important as lymph node involvement which up to now has been the single most important prognostic criterion. There are those who feel estrogen receptors have an equal prognostic value. There are others who feel it's not quite nearly as important.

Dr. Benson: Some of the problems in breast cancer recurrences might be due to a rather less conservative approach with tendency in the last decade toward simple mastectomies and such. Do you think that some of the problems with recurrences are perhaps related to that?

Dr. Rosen: No. I really don't. I think it's a very minimal effect, if any. I don't think there is any evidence that it impacts on survival. The only area where it might have marginal impact is on local recurrences. In other words, the less radical procedures probably are associated with a moderate increase of local recurrence, but there is absolutely no good data to show that they are associated with a worsening survival. I suspect that the magnitude of the initial surgery has only a modest influence and is not going to be translated into any meaningful change in survival. I really doubt that the magnitude of the surgery is going to be the issue here. The issue is micrometastatic disease — that's the issue in all of the malignancies — the ability to identify unsuspected metastasis which we are terribly poor at, except by

statistical predictions which are, as you well know, not great for the individual patient. I mean, we basically make recommendations in oncology today based upon our predictive ability, which in the case of breast cancer: "are lymph nodes involved? . .If so, how many? . .Is the estrogen receptor positive or negative? . .how old is the patient? . ." These are the extremely gross tools that we use. What we really need and what we don't have is a way of separating the patient who has micrometastasis and is going to die unless something is done at some point, from the one who has already been cured. All we can do is utilize these very crude predictors on a statistical basis; they don't work very well for individual patients. I'd like to be able to look at a patient and say to that patient, 'I think you definitely need more treatment', versus, 'I'm not sure. . .you probably do, but we just don't know for sure'. We're really in that 'never never land' in many areas of cancer. What we need is a treatment that works and a way of knowing which patient needs it — those are the things we need. It's simple in some areas but difficult as hell in others.

Dr. Chait: Are there any cancer patients in which you would feel fairly secure giving them life insurance right after surgery? What group would you consider?

Dr. Rosen: Yes, I think there are some that I would feel fairly secure. I think a colon cancer patient who has so called Duke's A, which would be just submucosal invasion. You're talking over 80, say 90% 5 year survival. . .it's not 100% but it's getting close. I think that kind of colon cancer is extremely likely to be cured. I'd also say superficial melonama, Level I or II, Level I for sure. . .the statistics look good. If you're in the business to be 100% right, then you can't deal with that. I don't think there are any gastric cancers I'd do with. I wouldn't go with a lung cancer either. If you look at 100 cases of colon cancer, less than 10 of them are going to be Duke's A, so you're talking about a minority of cases where you'd want to stick your neck out.

Dr. Chait: You just mentioned gastric cancer. I have recently read about very good results achieved in Japan through early diagnosis achieved by doing early gastroscopy.

Dr. Rosen: We have not been able to duplicate that experience here. It might be a different kind of disease. They talk about very small, microinvasive lesions that they are extremely skilled at picking up gastroscopically. I don't think we have that data.

Dr. Benson: I must honestly say that I don't think that in the last four years I have seen an applicant with gastric carcinoma. It's almost a non-entity.

Dr. Chait: So let's go back to the list. Which others do you think we could insure right after an apparently successful treatment and expect a 90% survival or better.

Dr. Rosen: I think a Stage I seminoma, clinically confined to the testicle showing no spread of disease.

Dr. Benson: What if it has spread to the regional lymph node?

Dr. Chait: Then you should wait 2 years?

Dr. Rosen: 2 years of disease free follow-up, implying both adequate treatment and adequate follow-up.

Dr. Chait: So in 2 years you should have a normal chest X-ray, a negative AFP and a negative CAT scan.

Dr. Rosen: Some kind of study of the retroperitoneal nodes.

Dr. Chait: What other conditions do you think that you could put into that list?

Dr. Rosen: Thyroid. A young woman with papillary carcinoma of the thyroid. I would be careful with older patients, especially older male patients with follicular carcinomas because they have a much poorer prognosis. I think that young female patients with papillary or mixed papillary follicular carcinomas that have not invaded through the capsule are a good risk. I'm not convinced about older patients. I think they're different diseases in the older patients. Many are follicular rather than pure papillary or papillary-follicular. The incidence of bone involvement goes up in follicular thyroid cancers.

Dr. Chait: I had already written down a question. Papillary or papillary-follicular cancer of the thyroid. Can we go standard right after surgery in age less than 30 if no evidence of metastasis?

Dr. Rosen: Yes.

Dr. Chait: Even in males?

Dr. Rosen: Yes. For a male age less than 30, I would say yes.

Dr. Chait: What about follicular without evidence of capsular invasion and no evidence of distant metastasis?

Dr. Rosen: In what age group?

Dr. Chait: Still under 30.

Dr. Rosen: That's uncommon.

Dr. Chait: They occur in older patients.

Dr. Rosen: Yes, and they have a higher recurrence rate.

Dr. Chait: So what would your advice be?

Dr. Rosen: I would say that in that disease, as you know, recurrence is going to occur late. I would be guarded in an older patient over age fifty with a follicular carcinoma of the thyroid. I would not be anxious to take that patient without a 5 year period of disease free survival.

Dr. Chait: So "cured" would be five years after surgery?

Dr. Rosen: I think your problem here is that you picked an uncommon entity in follicular--it's not common in young patients. I don't know how many such patients have been followed. The older patients have a higher incidence of metastasis.

Dr. Chait: How susceptible are those metastasis to radioactive iodine treatment?

Dr. Rosen: They are susceptible but I'm not sure that we can cure them and achieve a normal survival.

Dr. Chait: What about medullary carcinomas of the thyroid?

Dr. Rosen: It has a higher recurrence rate and a higher mortality. It has a much lower incidence than papillary carcinoma of the thyroid and it is much more malignant.

Dr. Chait: What about papillary or follicular without capsular invasion but with cervical node metastasis, treated with surgery and Rx I ablation till achievement of a negative scan. When do you think that they are cured?

Dr. Rosen: Five years. Those with cervical node metastasis do better than the ones with invasion of the capsule. Invasion of the capsule prognosticates poorer than does lymph node metastasis, which is unusual.

Dr. Chait: Let's go on with our list. We have not discussed Hodgkin. What about Stages I A and I EA?

Dr. Rosen: You can put in that group even II A. Right after completion of radiation treatment, we are talking about 80 to 85% relapse free survival at five years and most of the relapses are salvageable with chemotherapy. A few are going to develop acute leukemia later on. So far that number is less than 5% in most series, and occurs within ten to fifteen years.

Dr. Chait: I recently insured at a low rate a Stage III B applicant with Hodgkin that had been treated by a combination of radiation therapy and chemotherapy six years earlier and had no evidence of recurrence. Do you think that that approach was correct?

Dr. Rosen: Yes, he is most likely cured but still at risk of developing acute leukemia in the future.

Almost all recurrences of Hodgkin's occur within 3 years from completion of treatment. The important thing is to know that the patient is free of disease, and this requires a very thorough evaluation. It is a critical area. You must be careful because the standards of care are different among the doctors that deal with these patients. I feel that in this kind of case you should seek consultation with an oncologist in order to ascertain that the patient's evaluation has been adequate.

Dr. Chait: Continuing with our list, what do you think of the strict vocal cord cancers, not the supraglottic.

Dr. Rosen: You are talking of limited disease, without metastasis. Survival is very high — you may include them in the list.

Dr. Chait: I can't think of any other tumors that I could fit into that list. Can you think of any others?

Dr. Rosen: There are a few others. Some prostate cancers in which the cancer is an incidental finding at the time of a prostatectomy for a benign prostatic hyperplasia. The pathologist finds cancer in one or two of the chips removed during the TUR. These are the so called in situ carcinomas of the prostate or early Stage A. There is even a question on whether

they are true cancers from a biological standpoint. I believe we are almost begging the issue by calling them cancers. On the other hand, a cancer of the prostate that is multifocal, involving several areas or that is already palpable as a hard nodule is a different disease.

Dr. Chait: The problem that we have is that unfortunately the Rating Manuals of Insurance Companies have tried to simplify this very complex problem and have lumped the different malignant tumors into 5 or 6 different categories allowing a few to be considered without any postponement and have spread the others up to a maximum postponement of 5 years after completion of treatment for the worst cases.

Dr. Rosen: You have to reach a balance between oversimplification on one hand and becoming so complicated that you cannot reach any decisions on the other hand. You must try to find a happy medium between these two extremes. Prostate and bladder cancer are very tricky areas for ascertaining prognosis.

Dr. Benson: What do you think would be safer, to accept cancer patients with a sizable up front payment right off the operating table or to insure them with little or no extra premium five years after surgery.

Dr. Chait: What kind of cancers do you have in mind? I don't think that we can make that kind of general question because cancers are so different.

Dr. Rosen: I think that an increase in premiums might not even be indicated in some of these situations. On the other hand I don't think that any premium increase within the frame of sanity would cover the risk involved in other neoplasms. There is no way in which patients with lung cancer or pancreatic cancer or esophageal cancer could by covered right after surgery. Outside of the list of conditions that we have already discussed that might be insured early I cannot envision how you could insure other patients right after surgery when you have statistical evidence that shows that more than half of them are destined to have recurrences. How could anybody afford the cost of that kind of insurance? I think that unfortunately, for the bulk of serious cancers that affect mankind, you are stuck.

Dr. Chait: What kind of cancers did you have in mind Dr. Benson?

Dr. Benson: I'm talking about an ovarian cancer.

Dr. Chait: I believe that ovarian cancer is a pretty bad tumor.

Dr. Rosen: There are a few small unilateral ovarian cancers in which the capsule has not been involved. In them you get 70-80% "5 year cures". How often do you see these? Very infrequently. The vast majority of ovarian cancers are not in that category. These are usually incidental findings. The patient goes in for a hysterectomy and at the time that they cut the ovary at surgery they find a small unexpected ovarian cancer. Those patients have a 20% or 30% recurrence rate in 5 years. I suspect that's where you have your ups and downs. You would obviously increase their premiums sustantially, but you might be willing to take them on at that point. I don't know. This kind of cancer is a good example, but it is a rarity.

Dr. Rosen: The other area we might talk about is microinvasive endometrial cancer, well differentiated. I think some of those patients could be insured up front.

Dr. Chait: What do you mean by microinvasive, reaching to what depth?

Dr. Rosen: Less than 20-30% of the myometrium, minimal, well differentiated. The uterus is not enlarged by palpation. Many of these patients have been on estrogens. I think some are probably exaggerations of hyperplasia of the endometrium in which malignancy lies in the eye of the beholder. It's a microscopic evaluation. Where does cancer begin and hyperplasia end? I think that kind of a patient could be insured up front. And I'm sure you also insure cancer of the cervix in situ.

With ovarian cancer, you'd have to be terribly careful because there are too many examples of ovarian cancer where the patient was thought to have been cured and the disease recurs.

Dr. Benson: What about carcinomas of the prostate?

Dr. Rosen: Well I would say that unless it is a Stage A carcinoma of the prostate with only a few chips involved — you'd want to know what type of procedure and how it was diagnosed, was it diagnosed by a TUR, by a prostatectomy, by a suprapubic prostatectomy, how many chips showed the cancer — you'd have to know. . .

Dr. Chait: Were the seminal vesicles involved?

Dr. Rosen: No. I'm talking about Stage A, which is occult disease. We're talking about an organ that is extremely hard to evaluate clinically and pathologically, the degree of evaluation is frequently inept. A few little pieces of tissues come out and you're supposed to make a prognosis on that. It's not fair to ourselves.

Dr. Chait: And you cannot even palpate the lymph nodes, you don't know what's going on unless they have been studied.

Dr. Rosen: Yes, that's right. It's a very tough area. Of course, fortunately, most of these people are at an age where they're not looking for life insurance, but I'm sure you see it.

Dr. Benson: Where would you feel more comfortable from a purely profit making consideration: in a selective up front cancer offering right off the operating table where the individual is paying roughly 8 to 10% of the death benefit the first year and maybe for the next few years, versus taking them at a very much lower premium in the fourth year and beyond, with usually far less medical follow up at that point.

Dr. Chait: What do you mean by selective?

Dr. Benson: Well, I would be excluding certain lung cancers, cancer of the pancreas and metastatic disease.

Dr. Chait: What do you mean by, "excluding metastatic disease?" How would you do that?

Dr. Benson: Well, where the surgeon tells you that he has not seen any metastasis.

Dr. Chait: So, what you mean is excluding gross metastatic disease visible at surgery.

Dr. Rosen: My instincts, never having done this before would favor your second option. In other words, I feel that those four or five years of follow up are probably more valuable than most of the things that we think we know at the time of surgery.

Dr. Benson: We're talking three years of follow-up, with assurances at the end of that third year and entering the fourth.

Dr. Rosen: It would really depend on the kind of cancer.

Dr. Chait: You cannot generalize.

Dr. Rosen: No, I'm afraid you can't.

Dr. Benson: I realize that.

Dr. Rosen: You're in a position there where, first of all, the three year delay is a tough period. You're in the middle of an analysis period. Secondly, I'm impressed by our inability at the time of diagnosis, to go much beyond what we've said already. I mean you can't very well — intelligently that is — look at a woman with breast cancer who has lymph node involvement and insure her up front except at an extraodinarily high rate. It doesn't mean she's going to be dead in five years, but she's going to be dead statistically in higher incidence in ten years. I don't know how you look at that same woman three years later and do much better. All you can say is she hasn't shown any evidence of recurrence at three years. I don't think you can intelligently. . .

Dr. Benson: But we do. . .

Dr. Rosen: We do? But what are you doing?

Dr. Chait: We do and I think it's wrong. In fact, I went to our actuaries with tables showing breast cancer recurrence after 15 and 20 years, and the mortality curve never flattens out. Their advise was that if we want to insure breast cancer, we should change our rates, and go to rates that would be completely uncompetitive with the rest of the industry. We are better off not insuring them, except the very best cases, the cream of the crop. By this I mean the small tumors without lymph node metastasis and several years postop.

Dr. Rosen: The easy ones. . .and you're still going to lose some of those, but at least you know your batting averages.

Dr. Chait: Exactly.

Dr. Rosen: Well, I think that what you've said indicates that probably an awful lot of people in the

industry don't understand what they are doing. I don't mean any criticism intended, but if they don't understand the variability in each type of cancer, what the prognostic variables are. . .they're doomed to error. Anybody who would take a breast cancer case and try to somehow equate it with a lung cancer case, for example, would be, I think, doing a disservice to the company as well as the patient. It depends what you're after. You're obviously after good risks, and if you're after bad risks you want to be sure they pay for it. I think there are good guidelines to identify gross areas where you want to stay clear, and there are good guidelines for finding those who are good risks. I think there are a lot of problems in between. What do you do with postponing for three years? That's a terrible area to be stuck in. I'm not sure that you want to get stuck in it.

Dr. Benson: We are. I feel awfully naked.

Dr. Rosen: You are. That's what I'm saying. How do you make a rational decision for an individual person with, let's just take for example, a Duke's C carcinoma at three years? I mean you obviously can't predict what is going to happen to him.

Dr. Chait: I would not take him.

Dr. Rosen: That's what I'm saying. I can't see constructing a rational plan for that person.

Dr. Benson: That's why in many ways I seek reassurance. . .the man does not have gross metastasis. . .

Dr. Chait: But if he was a Duke's C, he already had lymph node metastasis.

Dr. Rosen: Let me give you a hypothesis. Suppose you were given the raw statistics at the time of surgery that yes, the surgeon removed all the gross tumor, but the pathologic findings indicate a 40% chance of recurrence within five years. What are you going to do with that?

Dr. Chait: If I received information that someone has a statistical chance of 40% recurrence within 5 years I would consider him uninsurable.

Dr. Rosen: OK. You wouldn't go a step further?

Dr. Benson: Who could afford it?

Dr. Rosen: There's no way you could balance that. What I'm saying to you is that there are a tremendous number of cases where the recurrence rate is somewhere between 40 and 60% within five years. It seems irrational to me to try to insure those cases without a waiting period of at least five years.

Dr. Chait: It seems to me that in the group of tumors that have a mortality curve that flattens out at 5 years we can make a reasonable offer after three years if the risk of recurrence is below 25% within 5 years.

Dr. Rosen: What is really critical for you to watch is when the mortality curves flatten out in the different kinds of cancers. Look at the "End Results in Cancer" publication of the American Cancer Society. Don't make the terrible mistake of relying on studies involving small numbers of patients.

Dr. Chait: I had forgotten to ask you about another tumor in which there has been a recent remarkable progress in treatment. How about the non Hodgkin Lymphomas, the diffuse and more anaplastic ones? I have read that the few that are doing OK two years after treatment are most likely cured.

Dr. Rosen: You're right, the histiocytic lymphomas.

Dr. Chait: There is something paradoxical here. The tumors that appear to be worse, that are more anaplastic and that have already diseminated are in some cases curable while others that are much less malignant have no adequate treatment.

Dr. Rosen: That's right because the more malignant ones are more susceptible to chemotherapy.

Dr. Chait: How about chronic lymphocytic leukemia versus the leukemic phase of a well differentiated lymphocytic lymphoma?

Dr. Rosen: I think that is mainly a semantic problem, I believe it is the same illness. Those that do not have anemia or decreased platelets, that do not have palpable lymph nodes or a markedly enlarged spleen, are asymptomatic, and stay like that for a couple of years, usually have a benign course with a survival of over 10 years from the date of diagnosis. There is a group of patients that at the time of diagnosis already have a severe anemia and thrombocytopenia and have a poor prognosis. These people are usually in their seventies. It

is not common to see this condition in people below their sixties. It is easy to pick up the bad group right off the bat. The first group is not as easy. Drs. Rai and Rosner have written extensively on chronic lymphocytic leukemia and have shown that the average survival in Stage Zero, which is simply lymphocytosis alone, is in excess of ten years. Stage I which has lymphadenopathy plus the high white count has a very similar survival. Stage II which includes hepato and or splenomegaly has a steeper mortality curve although the average exceeds five years. This is a heterogeneous group whose behavior is difficult to predict. In Stages III and IV which show anemia and thrombocytopenia median survival drops to less than three years.

Dr. Chait: This is very important because the Rating Manuals of most insurance companies just state chronic lymphocytic leukemia and give a tentative rating without discriminating between the different stages.

Dr. Rosen: On the other hand, chronic granulocytic leukemia is by definition non insurable. Another area that you should start to look into as an experimental group is acute leukemia in adults as well as aplastic anemia when they have been treated with bone marrow transplantation. In any case they should be postponed for at least two years because there is an early mortality that is due to complications from treatment. I think those people might become insurable in the future although at a substantial rate because we don't have information on their long-term prognosis. The leukemia is cured but they might develop other unknown problems.

Dr. Chait: Dr. Rosen and Dr. Benson, I want to thank you for your participation in this discussion.

Mike Gorman, Marvin Moser, M.D.. Edward Frohlich, M.D., and Jerzy Gajewski, M.D. prepared the following letter to be sent on behalf of the National High Blood Pressure Coordinating Committee to chief executive officers of life and health insurance companies.