

7. Ag 1/2: C16/2/981  
14  
[COMMITTEE PRINT]

96TH CONGRESS }  
2d Session }

HOUSE OF REPRESENTATIVES {

B 1,022,381

# CANCER INSURANCE: EXPLOITING FEAR FOR PROFIT

(An Examination of Dread Disease Insurance)

## REPORT

(Together With Additional Views)

BY THE

### SELECT COMMITTEE ON AGING NINETY-SIXTH CONGRESS

SECOND SESSION

Comm. Pub. No. ~~96-202~~



MARCH 25, 1980

U.S. GOVERNMENT PRINTING OFFICE

87-614 O

WASHINGTON: 1980

For sale by the Superintendent of Documents, U.S. Government Printing Office  
Washington, D.C. 20402

Stock No. 052-071-00609-5

PURCHASED THROUGH  
DOC. EX. PROJECT

BUHR STRASSE

**SELECT COMMITTEE ON AGING**

**CLAUDE PEPPER, Florida, *Chairman***

**EDWARD R. ROYBAL, California**  
**MARIO BIAGGI, New York**  
**IKE F. ANDREWS, North Carolina**  
**JOHN L. BURTON, California**  
**DON BONKER, Washington**  
**THOMAS J. DOWNEY, New York**  
**JAMES J. FLORIO, New Jersey**  
**HAROLD E. FORD, Tennessee**  
**WILLIAM J. HUGHES, New Jersey**  
**MARILYN LLOYD BOUQUARD, Tennessee**  
**JIM SANTINI, Nevada**  
**ROBERT F. DRINAN, Massachusetts**  
**DAVID W. EVANS, Indiana**  
**MARTY RUSSO, Illinois**  
**STANLEY N. LUNDINE, New York**  
**MARY ROSE OAKAR, Ohio**  
**ELIZABETH HOLTZMAN, New York**  
**JIM LLOYD, California**  
**THOMAS A. LUKEN, Ohio**  
**WES WATKINS, Oklahoma**  
**LAMAR GUDGER, North Carolina**  
**GERALDINE A. FERRARO, New York**  
**BEVERLY B. BYRON, Maryland**  
**WILLIAM R. RATCHFORD, Connecticut**  
**DAN MICA, Florida**  
**EDWARD J. STACK, Florida**  
**HENRY A. WAXMAN, California**  
**MIKE SYNAR, Oklahoma**  
**EUGENE V. ATKINSON, Pennsylvania**

**CHARLES E. GRASSLEY, Iowa,**  
*Ranking Minority Member*  
**WILLIAM C. WAMPLER, Virginia**  
**JOHN PAUL HAMMERSCHMIDT, Arkansas**  
**JAMES ABDNOR, South Dakota**  
**MATTHEW J. RINALDO, New Jersey**  
**MARC L. MARKS, Pennsylvania**  
**RALPH S. REGULA, Ohio**  
**ROBERT K. DORNAN, California**  
**HAROLD C. HOLLENBECK, New Jersey**  
**S. WILLIAM GREEN, New York**  
**ROBERT (BOB) WHITTAKER, Kansas**  
**NORMAN D. SHUMWAY, California**  
**LARRY J. HOPKINS, Kentucky**  
**OLYMPIA J. SNOWE, Maine**  
**DANIEL E. LUNGREN, California**

**CHARLES H. EDWARDS III, *Chief of Staff***

**YOSEF J. RIEMER, *Deputy Chief of Staff***

**VAL J. HALAMANDARIS, *Senior Counsel***

**JAMES A. BRENNAN, *Assistant to the Chairman***

**WALTER A. GUNTARP, Ph. D., *Minority Staff Director***

## PREFACE

---

MARCH 17, 1980.

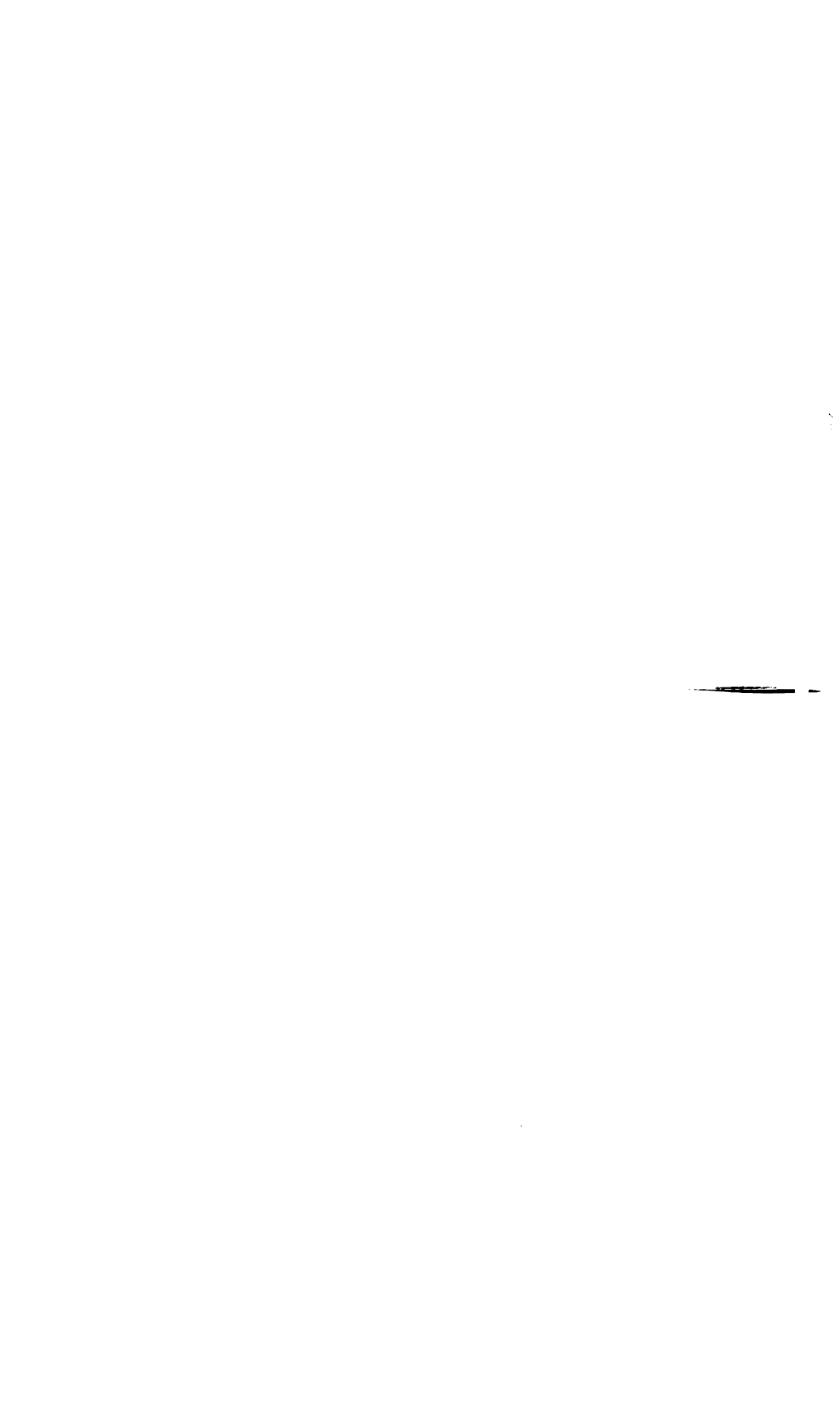
On behalf of the House Select Committee on Aging, I am hereby presenting a report entitled, "Cancer Insurance: Exploiting Fear for Profit."

This report grows out of our investigation of questionable practices in the sale of health insurance to the elderly which began in March 1978. In the course of our work, we documented widespread abuse. We found that senior citizens were often being sold multiple, unneeded and duplicate policies purportedly in supplementation of Medicare, the Federal health insurance program for the aged. All too often, these policies were sold with the rationale that they would pay everything that Medicare wouldn't—a blatant misrepresentation. Even worse, the policies generally contain a clause which says that in case of duplication, only one policy will pay.

In the course of our investigation, we found that among the multiple, unneeded or duplicative policies frequently held by the elderly were those marketed to pay for health expenses if and only if the policyholder developed a single dreaded disease—cancer. We soon learned that cancer insurance is a highly controversial subject. Our staff report, "Abuses in the Sale of Health Insurance to the Elderly: A National Scandal," dated November 28, 1978, contains our interim findings on the subject of cancer insurance and notes that we felt the matter was so important that a broad scale study was necessary. This report is the result of that expanded effort.

This report, which has been more than a year in the making, represents the most comprehensive study of cancer insurance ever undertaken. It concludes that there is good reason for concern about the limited value of cancer insurance and the fear tactics which are used to market it. From our point of view, there is particular concern that so many of these policies are being sold to the elderly who generally have no need for or will not benefit from them. Our report contains several recommendations to the Congress and to the States for dealing with the problems which have been highlighted in our study.

CLAUDE PEPPER, *Chairman.*



# CONTENTS

---

	Page
Preface .....	III
Summary of This Report.....	1
I. Introduction .....	5
II. Perspective: The Players, The Numbers, The Terms.....	12
III. The Chronology of Studies and Investigations.....	22
IV. Market Conduct Examinations of Four Major Cancer Insurers.....	77
American Family Life Assurance Co.....	78
American Income Life Insurance Co.....	101
Union Fidelity Life Insurance Co.....	107
Washington National Insurance Co.....	136
V. What State Regulators Say About Cancer Insurance.....	143
Results of the study.....	143
Selective comments from the States.....	145
An in-depth investigation of cancer insurance: Massachusetts.....	154
VI. Response From the Industry: A Poll of Health Insurance Companies .....	170
VII. The Special Problem of Mail Order Insurance.....	183
VIII. Findings and Conclusions.....	209
IX. Recommendations and Additional Views.....	252
<b>Appendixes</b>	
Appendix I. Committee questionnaire on Dread Disease Insurance sent to all State Commissioners of Insurance.....	257
Appendix II. Committee questionnaire on Dread Disease Insurance sent to the top 50 Health Insurance Companies.....	259
Appendix III. Committee questionnaire on Mail Order Insurance sent to all State Commissioners on Insurance.....	261
Appendix IV. Letter from Peter D. Morrow, American Family Life Assurance Company of Columbus, Ga., to all American Family associates and managers .....	263
Appendix V. Correspondence between Chairman Pepper, Congressman Seiberling, and Commissioner Gunter of the Florida Insurance Commission concerning supplemental insurance advertising.....	264
Appendix VI. Examples of advertising material used in conjunction with sales of cancer insurance through credit unions.....	287



# CANCER INSURANCE: EXPLOITING FEAR FOR PROFIT

(An Examination of Dread Disease Insurance)

## SUMMARY OF THIS REPORT

This report and the investigation of cancer insurance by the Committee upon which it is based, grows out of the Committee's earlier study on the broader subject of abuses in the sale of health insurance to the elderly. In November 1978, the Committee released a report and held hearings which disclosed that senior citizens were often being sold several unneeded, duplicative and therefore, essentially worthless health insurance policies in supplementation of Medicare. The Committee learned that the impetus for these purchases was the aggressive tactics of unscrupulous companies or agents and the fact that it is costing the average senior more and more to participate in Medicare, and Medicare is paying less and less of their health care bills.

The Committee was surprised to learn that among the health insurance policies which frequently were held by the elderly were those which provided coverage for a single dread disease—cancer. The natural question presented is: Are these policies a good buy for the elderly?

After more than a year of investigating the topic, it is the primary finding of this report that such policies are not a good buy, that sales tactics used to sell such policies are highly questionable, and that such policies should not be sold to the elderly who have the benefit of Medicare and generally one or more Medicare supplementary policies besides.

Following are highlights of the report. Section VIII, "Findings and Conclusions" provides more detail.

### GENERAL DATA

- Some 4 million cancer insurance policies were sold in the United States during 1979 and there are an estimated 20 million of them in force at the present time. These policies are offered by some 300 companies—most of them small and comparatively anonymous—but only a few of these companies actively market this line of insurance.
- Cancer insurance sales are dominated by American Family Life Assurance Company of Columbus, Georgia which is said to account for more than half of the total market. Fueled by sales in Japan as well as in the United States, the Company was recently named by *Forbes* magazine as the most profitable and fastest growing in the United States. Other major sellers include Union Fidelity Life

Insurance Company, American Income Life Insurance Company, and Lone Star Life Insurance Company. See Table I, page 12 for more details.

- Most cancer policies are sold on an individual as opposed to a group basis. Premiums range from \$35 to \$75 for one person and from \$45 to \$150 for a family. Estimating an average cost of \$75 per policy per year, Americans spent \$1.5 billion for cancer insurance last year, or about 3 percent of the \$45 billion that they spent for health insurance in general.
- Partly because of American Family's success, cancer insurance is the fastest growing and most profitable line of insurance.
- Cancer insurers claim that 1 in every 4 persons will have cancer, but actual statistics are more heartening. The American Cancer Society indicates that there will be 765,000 cases of cancer in 1979 among the U.S. population of 217.6 million. In short, one in every 280 persons may develop cancer each year but even this statistic creates a misleading impression. About one fourth of the cases will be made up of inexpensive, curable, skin cancer. It is estimated that half of all cancer victims could be saved with early diagnosis and prompt treatment. To be sure, cancer is an expensive disease; the average lifetime costs of having cancer is close to \$10,000. Still, it is important to keep in mind that cancer accounts for only 19.4 percent of all deaths according to U.S. vital statistics reports.

#### PREVIOUS STUDIES AND INVESTIGATIONS

Section III of this report, beginning on page 22 summarizes some 25 of the studies and/or investigations that have been done on the subject of cancer insurance. The reports are unanimous that (1) cancer insurance has very limited economic benefit to the purchaser, (2) scare tactics are used to market the product both by agents and by companies that sell through the mails, and (3) that rather than buy a cancer policy, an individual is better off expanding his or her existing comprehensive health insurance policy or in purchasing a supplementary policy (for roughly the same money) which covers health costs relating from other diseases and accidents.

#### POLL OF THE TOP 50 HEALTH INSURANCE COMPANIES AND COMMISSIONERS OF INSURANCE

Section V shows that a majority of State Commissioners of Insurance are in agreement that cancer insurance has limited economic value, that fear tactics are used to sell it, and that individuals are better off expanding their existing coverage. See page 143.

America's largest health insurance companies shared this view as noted in Section VI except that they were not willing to go on record as saying that fear tactics were used by companies that sell this product. However, they did make the point that it is unconscionable to sell cancer policies to senior citizens who are adequately covered with their combination of Medicare and one or more supplementary policies. See page 169 and following.

### MAJOR FINDINGS

Following are the major findings which the Committee reached prior to its recommendation that the sale of cancer insurance to the elderly be restricted. See Section VIII for more details on each point.

(1) Some companies sell disproportionate number of cancer insurance policies to the elderly.

(2) Some companies improperly imply an endorsement for their product from the American Cancer Society.

(3) Most insurance companies which sell cancer insurance use fear tactics to induce people to buy policies.

(4) Some companies exaggerate statistics to promote cancer insurance sales.

(5) Companies selling cancer insurance belabor cancer costs.

(6) Companies selling cancer insurance belittle basic health insurance coverage.

(7) Many companies selling cancer insurance mislead the consumer by misrepresenting or exaggerating the benefits of their policy.

(8) Some cancer companies falsely imply an association with the U.S. Government.

(9) Some cancer insurers use phony testimonials.

(10) Some companies sell cancer policies falsely claiming that they are cheaper "group" plans when they are really individual policies.

(11) Some cancer companies make phony promises that a patient will be paid twice for the same illness.

(12) Companies sometimes sell policies which have not been approved by the State.

(13) Some companies reduce benefits so that the policy the consumer receives provides less coverage than the one they bought.

(14) Some companies say their policies are guaranteed for life and that rates won't increase. However, rate increases are instituted nonetheless.

(15) Companies selling cancer insurance offer a product which has very limited economic value.

(16) Many people will never recover benefits from their cancer insurance policies because of coordination of benefits clauses contained in their major medical plans such as Blue Cross/Blue Shield policies.

(17) Money spent on the purchase of a cancer insurance policy could be better spent on improving one's comprehensive insurance coverage.

(18) Abuses by agents selling cancer or other dread disease insurance policies are widespread.

(19) Companies selling cancer insurance exercise little control over agents; agents licensing and training are inadequate.

(20) Cancer policies frequently include uncommon restrictions and limitations.

(21) Cancer policies cover only cancer; with the exception of American Family, most companies imply coverage for other health problems.

(22) Although most cancer costs are incurred outside the hospital, cancer policies unfortunately, are geared to pay for cancer costs only when the individual is in the hospital.

(23) Although cancer, by its very nature, brings on related medical problems, many cancer insurance policies do not pay for the costs of these complications.

(24) Some cancer policies will pay only for a certain time limit after cancer is diagnosed; a fact which is not always made known to the policyholder.

(25) In order to limit their liability, most cancer insurers won't pay until cancer is diagnosed by a pathologist, which can be a costly, or life threatening procedure.

(26) In cancer policies, what the big print gives you, the little print takes away.

(27) Cancer insurance policies often employ obtuse legal jargon or other language which confuses the consumer.

(28) Many cancer insurers promise mountains of benefits but deliver molehills of protection.

(29) Even the proffered peace of mind that cancer insurers say they offer is illusory.

(30) Many companies selling cancer insurance have high rates of denial or errors in their payment of claims.

(31) There are serious shortcomings in the procedures for resolving complaints among major cancer insurers.

(32) Some state Insurance Commissioners are lax in their regulation of cancer insurance sold by agents.

(33) Insurance sold by mail, particularly mail order cancer insurance, presents special problems and is essentially beyond the reach of State regulators.

#### RECOMMENDATIONS

1. The Congress should require that policies sold to the elderly in supplementation of Medicare provide broad coverage and are not limited to providing protection against the costs of incurring a single dread disease.<sup>1</sup>

2. The states should carefully review and upgrade their regulation of cancer insurance with an eye toward providing requisite protections for all Americans.

3. The Congress should act immediately to help the states regulate and close the no-man's land which presently permits mail order firms to sell cancer and other health insurance policies in states where such policies are not filed with and approved by the Commissioner of Insurance of that state.

---

<sup>1</sup> Congress is very close to implementing this recommendation. H.R. 2602 as introduced by Congressman Pepper and cosponsored by 265 Members of the House would establish a voluntary program of certification so that those companies whose policies met minimum standards could receive a federal seal of approval from the Secretary of Health, Education, and Welfare. This proposal has cleared the House Ways and Means Committee and the House Interstate and Foreign Commerce Committee as well as the United States Senate. The Senate added the proposal offered by Senators Baucus and Culver to H.R. 3236, The Social Security Disabilities Amendments of 1980.

# CANCER INSURANCE: EXPLOITING FEAR FOR PROFIT

(An Examination of Dread Disease Insurance)

## I. INTRODUCTION

In November 1978, the House Select Committee on Aging released the results of its investigation of abuses in the sale of health insurance to the elderly. Committee Chairman Claude Pepper called the problem "a national scandal of staggering dimensions." He said that some insurance companies and their unscrupulous agents have become merchants of fear. "Capitalizing on the anxiety about ever-escalating health costs, they have conspired to sell senior citizens multiple, unneeded, duplicative and therefore, essentially worthless insurance policies in supplementation of Medicare, the national health insurance program for the elderly," charged Chairman Pepper.

The Committee's report "Abuses in the Sale of Health Insurance to the Elderly: A National Scandal" estimates that senior citizens are being taken for as much as \$1 billion out of the \$4 billion they spend for Medicare supplementary policies each year.

The report concludes that the root cause of the widespread abuse is the fact that senior citizens are afraid. Every day they face the twin buzz saws of ever-escalating health care costs and constantly decreasing Medicare coverage. Every day their fear of getting sick, of going broke, of going into a nursing home or of becoming dependent upon loved ones is intensified. Motivated by fear, they buy hope in the form of one or more insurance policies not realizing that there is no policy or combination of policies that they can buy that will plug Medicare's gaping holes and provide them with the comprehensive coverage they desperately want. Understandably, senior citizens are ready victims for fast talking insurance agents.

The Committee found that it was not uncommon for senior citizens to have 3, 5, 10, 30 and in one instance 91 different insurance policies. In the most blatant example to come to the Committee's attention, a 76-year-old Illinois woman paid over \$50,000 in insurance premiums over 10 years and was forced to remortgage her farm to keep up with the premiums. The saddest part of the story is that most of these policies contain a clause which says that in the case where an individual has more than one policy, only one will pay.

In the course of its investigation, the Committee learned that in addition to Medicare supplementary policies, the elderly were being sold thousands of single disease or so-called dread disease policies. These policies take their name from the fact that they provide limited coverage for expenses incurred if a person contracts one particular horrible disease. In the 1950's, many companies promoted polio insurance. By 1980, the phrases "single disease" or "dread disease" insurance have become virtually synonymous with cancer insurance.

While a small part of the Committee's November 1978 report relates to cancer insurance, it was decided that this controversial subject required a more detailed analysis. This report is the result of that effort.

The Committee was concerned about evidence suggesting that half or more of all cancer policies may be sold to senior citizens. Some companies selling cancer insurance claim that they do not target the elderly. However, the records of the nation's largest mail order cancer insurer indicate that over 80 percent of the firm's customers are over age 60. Pointing to the fact that Americans over age 60 account for 75 percent of all cancer deaths, industry spokesmen argue that the elderly need cancer insurance. Critics, on the other hand, respond that the elderly are already adequately protected by Medicare and other supplemental insurance. They go so far as to say senior citizens are the best insured against cancer and that the sale of cancer and other catastrophic insurance to this group would be duplicative and unconscionable.

Critics of cancer insurance charge that it is close to being a worthless product. They say that out of the thousands who will buy the insurance, few will ever see any return for their investment. They point to the high profits of cancer insurance companies which typically keep from 60 to 80 cents on each premium dollar for themselves. Critics say the policyholders would make a better investment by putting their money in a Las Vegas slot machine which keeps on the average 5 to 30 percent, returning the rest to the gambler.<sup>1</sup>

Critics also object to the sales techniques employed by cancer firms. They condemn the practice of mail order firms in sending out brochures with huge white letters on a black funereal background warning: Cancer Kills—What happened to each of the following list of famous persons CAN HAPPEN TO YOU. The sales pitches of agents are also condemned as being designed to accelerate existing fears to the point where the potential customer is so irrational as to beg for any life raft available, including the proffered salvation of a cancer insurance policy.

[See following pages.]

---

<sup>1</sup> Scarne's New Complete Guide to Gambling, p. 441, Simon and Schuster, N.Y.

**CANCER**  
**can happen**  
**to**  
**YOU**

**BABE RUTH  
NAT "KING" COLE  
GARY COOPER  
SPIKE JONES  
JACK BENNY  
GYPSY ROSE LEE  
WALT DISNEY  
SOPHIE TUCKER  
BABE ZAHARIAS  
CHET HUNTLEY  
VINCE LOMBARDI**

**CANCER  
...happened to them!**

It is charged that such policies are sold in superstition, that their prime benefit is to act as a talisman to ward off cancer; it may not always be clear that such policies provide very limited financial assistance for the medical costs incurred if and only if an individual develops cancer. Critics say that such policies offer a false sense of security. They are promoted as offering \$200,000 or \$250,000 worth of protection, and yet the few who actually develop cancer and meet other tests imposed by the policy, can expect an average payout of slightly more than \$1,000 per case.

It is charged that cancer policies make generous use of limitations and exclusions which may not be apparent at the time of purchase. For example, many policies will pay only after a cancer is diagnosed pathologically. This means the taking of a biopsy and examining the tissue under a microscope by a licensed pathologist. All too often, it is charged, as in the case of liver cancer, the surgery necessary to obtain the tissue sample may in itself be a fatal procedure. And then, too, it is asserted that most cancer policies will pay for few services outside the hospital and will not pay for the costs of therapy, rehabilitation or for the costs of diseases or injuries that result from cancer.

Finally, critics charge that cancer insurers unfairly minimize existing insurance coverage which will often pay substantial benefits if a person develops cancer. They assert that there is no reason why a senior citizen should think of buying a single disease policy when all seniors have the benefit of comprehensive health insurance coverage known as Medicare. And Medicare is a fine investment since 95 percent of the money invested is returned to the elderly and only 5 percent of the total paid into the program is lost in administrative expenses. The final argument made by critics is that for approximately the same amount of money that is paid for single disease policies, a person can purchase a catastrophic major medical policy which provides protection against an unlimited number of diseases and medical problems.

Proponents of cancer insurance take the opposite point of view on just about every question. They claim that cancer insurance is a valuable product, that thousands of dollars are paid in claims to needy individuals who would otherwise be out of luck. They dispute the notion that cancer insurance is, by definition, a high profit-low benefit line. They say that even if few people actually benefit from claims, the remainder have not been cheated because they have received peace of mind.

In response to the charge that they employ fear tactics, proponents answer that all insurance is based on fear. They deny heightening these fears in order to sell their product saying the American Cancer Society and the media have already "sensitized" the public. They assert that they are only giving the public what it wants.

They say the exclusions and limitations in cancer policies are not unusual as compared with other health insurance policies. They emphasize the low cost of their product as compared with comprehensive insurance policies as an excuse for some of the language which limits when policyholders claims will be deemed compensable. They defend the use of maximum benefit figures saying it is theoretically possible to collect huge amounts of money if a person were hospitalized long enough.

In its investigation, the House Select Committee on Aging was faced with these conflicting assertions about the viability of cancer insurance. The Committee learned that 5 States have banned the sale of cancer or other dread disease policies and that several more States are considering this action. The question was why did the States take this action?

The Committee also received letters from citizens who bitterly complained about their cancer insurance policies. For example, a woman in Washington, D.C. learned that promised coverage set forth in the large print of her policy was effectively nullified by the small print on the back of her form. A woman in Oregon complained about the use of 180 word sentences in bogus legalese which seemed to be at variance with what the salesman had led her to believe would be the terms of her policy. A woman in Illinois did receive some help from her policy when she underwent a mastectomy but the company refused coverage for a broken leg which was caused by the cancer. A man in Virginia received \$750 from his company for his \$12,000 bill. A woman in Ohio suffered a relapse but payment was declined because the company had limited its liability to three years from the date that cancer is first diagnosed.

On the other side of the ledger, the Committee did receive several letters from people who asserted that cancer insurance had been a "God-send." One man from Indiana wrote that he had received several thousand dollars from his firm.

Accordingly, it was the task of the Committee in this report to gather facts to reconcile the disparate views about cancer insurance. In its investigation the Committee undertook the following steps:

- Prepared and sent a questionnaire to all State Insurance Commissioners at the Chairman's request. The responses to the questionnaire were tabulated, and appear in Section V of this report. The questionnaire can be found in Appendix I.
- Conducted follow-up telephone interviews with over one-third of the State Insurance Commissioners and their staffs.
- Reviewed all books, periodicals and newspaper references relating to cancer insurance in the possession of the Library of Congress.
- Reviewed all hearings and reports on the subject by congressional committees and administrative agencies.
- Asked every congressional office to save complaints received with respect to private health insurance for a period of one month. Thousands of such complaints were received by the Committee, many of which related specifically to dread disease policies.
- Requested, by order of the Chairman, that a investigation be undertaken by the General Accounting Office to evaluate the economic value of cancer policies marketed by major insurance companies. The findings of this investigation are detailed in Section III of this report.
- Prepared and sent a questionnaire to the top 50 insurance companies who represent more than 50 percent of all health insurance sold in the United States asking about their experience with cancer policies. The responses to this inquiry appear in Section VI of this report. The questionnaire can be found in Appendix II.

- Prepared and sent a letter, under the signature of the Chairman, to a number of notable and respected authorities on insurance to ascertain their views with respect to the economic value and marketing practices of cancer insurance.
- Maintained contact with the California, South Carolina and Massachusetts Insurance Departments since each was conducting detailed hearings and reports evaluating cancer insurance.
- Communicated with senior citizens and consumer organizations asking if they had experience with cancer insurance.
- Interviewed insurance agents to learn what abuses exist in the sale of cancer insurance and how widespread such abuses are as well as whether they result from official company policy.
- Studied the results of law suits brought in Federal courts by plaintiffs against insurance company defendants concerning cancer insurance policies over the past three years.
- Contacted several hospitals and famous cancer clinics to learn what record of payment they had from several cancer insurers.
- Recruited senior citizens and a Member of Congress to investigate firsthand whether agents use fear tactics and misrepresent cancer benefits in their sales presentations. The temporary investigators already had Medicare coverage as well as several additional supplemental insurance policies when confronted by agents. Insurance agents were contacted at random from the yellow pages of a telephone book and asked to advise the temporary investigators about whether their existing coverage would cover costs associated with cancer.
- As noted in the Committee's November 1978 staff report, Committee staff obtained positions as trainees with two firms selling cancer insurance to observe training methods for agents and the sales practices used by agents. Committee staff did not actually sell policies but merely observed how it was done.
- With the assistance of GAO, reviewed presentations to the Committee and to State insurance commissioners by major cancer insurers.

As a result of this investigation, the Committee concluded that the critics of cancer insurance were justified in their complaints. It is apparent that cancer and other dread disease policies have very limited economic value and that there are significant abuses associated with the marketing of these forms. There is good reason to question the sale of these policies to senior citizens and the Congress and or the States may wish to prohibit the practice.

## II. PERSPECTIVE: THE PLAYERS, THE NUMBERS, THE TERMS

The subject of health insurance, and particularly dread disease insurance, is a complicated and much misunderstood area. The purpose of this section is to give the reader a familiarity with the companies in the field, their size, the technical terms used within the industry and the abuses which have been identified, all of which are necessary for a complete understanding of what follows in this report.

The Committee was concerned about the paucity of data relating to cancer insurance. However, evidence is clear that it has become the fastest growing and most profitable line of insurance in the United States in the last 10 years. The best estimates available are that over 4 million such policies were sold in 1979 by some 300 mostly small and comparatively anonymous companies who have sold a total of 20 million cancer insurance policies in the United States up to the present time.

Only one of the Nation's top 50 major health insurance companies pursues the sale of cancer insurance, Mutual of Omaha. More than 50 percent of the market is said to be controlled by American Family Life Assurance Company of Columbus, Georgia.<sup>1</sup> Other major cancer sellers include Union Fidelity Life Insurance Company, American Income Life Insurance Company and Lone Star Life Insurance Company. See Table I for more details.

TABLE I.—Major Cancer Insurance Sellers<sup>2</sup>

American Exchange Life Insurance Company, Dallas, Texas.  
American Family Life Assurance Company, Columbus, Georgia.  
American Income Life Insurance Company, Indianapolis, Indiana.  
Colonial Life and Accident Insurance Company, Columbia, South Carolina.  
Combined Insurance Company of America, Chicago, Illinois.  
Commonwealth Life Insurance Company, Louisville, Kentucky.  
Commonwealth National Life Insurance Company, Cleveland, Mississippi.  
Equitable Life and Casualty, Salt Lake City, Utah.  
Home Beneficial Life Insurance Company, Richmond, Virginia.  
Home Security Life Insurance Company, Durham, North Carolina.  
Independent Life and Accident Insurance Co., Jacksonville, Florida.  
Insurance Company of America, Austin, Texas.  
ITT Life, Thorpe, Wisconsin.  
Liberty National Life Insurance Company, Birmingham, Alabama.  
Life Investors of Cedar Rapids, Iowa.  
Lone Star Life Insurance Company, Dallas, Texas.

<sup>1</sup> Statistics in this report suggest American Family's share of the market may be much less than the 50 percent attributed to it.

<sup>2</sup> Source: Committee questionnaire of Dec. 1978.

Monumental Life Insurance Company, Baltimore, Maryland.  
 Mutual of Omaha, Omaha, Nebraska.  
 Mutual Protective Insurance Company, Omaha, Nebraska.  
 National Ben Franklin Life Insurance Company, Chicago, Illinois.  
 National Casualty Company, Southfield, Michigan.  
 National Home Life Assurance Company, Columbia, Missouri.  
 National Western Life Insurance Company, Denver, Colorado.  
 Old American Insurance Company, Kansas City, Missouri.  
 Pioneer Life Insurance Company, Rockford, Illinois.  
 Reliable Life & Casualty Company, Madison, Wisconsin.  
 Rockford Life Insurance Company, Rockford, Illinois.  
 Standard Life and Accident Insurance Co., Oklahoma City,  
 Oklahoma.  
 Union Bankers Life Insurance Company, Dallas, Texas.  
 Union Fidelity Life Insurance Company, Trevese, Pennsylvania.  
 Washington National Life Insurance Company, Evanston, Illinois.  
 World Life & Health Insurance Company, King of Prussia,  
 Pennsylvania.

Cancer insurance policies are generally sold to individuals. Rarely are they sold to groups; group sales are generally organized at the place of employment, lower rates are available to individuals because a large pool of people are insured and finally, the employer as well as the employees, generally make payments towards premiums.

Cancer policies are sold at \$30 to \$75 per person per year while family coverage can be purchased for an annual premium of between \$45 to \$150 a year.

Assuming an average policy costs \$75 a year, the total cancer insurance market at the present time may amount to \$1.5 billion a year in sales. This is more than 3 percent of the \$45 billion that Americans spent for health insurance in 1979.

While national statistics are sketchy, recent in-depth studies confirmed the suspicion that a disproportionate number of cancer policies are sold to the elderly. While senior citizens account for 11 percent of the U.S. population, they may account for more than half of all cancer policies sold. For example, the Massachusetts Insurance Department found that nearly 80 percent of Union Fidelity's sales were to people over age 60. Studies of American Family Life Assurance Company show that the average age at purchase is 56 and the average age of claimants is 66. It is worth noting that American Family disputes this charge claiming that only 11 percent of their sales are to those over 65.

This saturation of sales among the elderly reflects both a heightened fear of cancer and sales targeting by insurance companies. And there is some basis for this fear. While heart disease continues to be by far the largest killer, cancer is second as an overall cause of death in the United States. Moreover, over 75 percent of all cancer deaths occur in those over age 60.

While cancer insurers try to sell the notion that one in every four Americans will contract cancer, actual statistics are more heartening. The American Cancer Society indicates that there will be 765,000 cases of cancer in 1979 among the U.S. population of 217.6 million.

In short, one in every 280 persons may develop cancer in any year, but even this statistic creates a misleading impression. About one-fourth of the cases will be made up of less serious and less costly skin cancer; an additional 10 percent will be colon cancers which also have a high rate of cure.

To be sure, a bout with cancer is expensive. The average person with cancer will spend about \$10,000 in his lifetime for medical treatment.<sup>1</sup> Once again, these figures are estimates and are not the kind of precise data which is needed, but unavailable.

For senior citizens the word "cancer" presents a double fear. First is the fear of the disease and possible death that results from it. Second, and almost as important, is the fear of financial ruin which may accompany cancer. Both fears have been exaggerated. Senior citizens who are covered by Medicare and by a good Medicare supplementary health insurance policy will have reasonable protection against the costs of cancer.

Given the shortcomings of Medicare which now covers only 38 percent of their average health costs, senior citizens have increasingly turned to health insurance. They reason, incorrectly, that if one policy is good, three will be better and five policies to supplement Medicare must be better still. It is in this context that senior citizens are persuaded to buy cancer insurance policies.

#### DEFINITIONS

The reader will need to understand commissions, loss ratios, the difference between service and indemnity policies, the distinction between policies marketed by salesmen and through the mail, and that the Federal Government has delegated the authority to regulate insurance to the State insurance commissioners. These terms and concepts are detailed below.

#### *Loss Ratios*

The ultimate question being examined in this report is: Are cancer insurance policies needed and helpful? Alternately: Do they have reasonable economic benefit for those who buy them? In this discussion of economic benefit, one concept is crucial and will reappear many times throughout this report. This concept is called a "loss ratio."

There are two basic kinds of loss ratios. The first is called the *anticipated* loss ratio. It represents what the company tells the State Department of Insurance it expects to pay back in claims. The *actual* loss ratio reflects what the company actually paid to their policyholders. While loss ratios are available for each policy sold by a company there are also *aggregate* loss ratios which represent payback figures on all the company's policies in force by year. Generally speaking, the higher the loss ratio the more money returned to pay the insured's claims and the better the policy from the point of view of the insured.

The General Accounting Office offers this definition:

The loss ratio is the proportion of gross premiums which, on the average, is returned to policyholders in the form of benefits. As such, it is an indicator of the economic value of a

<sup>1</sup> If skin cancer is eliminated from the computation, the average lifetime cost is closer to \$20,000. Cost estimates by the Massachusetts Department of Insurance.

policy form or forms offered for sale by an insurance company. Loss ratios are generally expressed as percentages. For example, if the loss ratio for a year (or other specified period) were 55 percent, this would mean that total benefits paid to policyholders—for illnesses originating during the period—would amount to 55 percent of the premiums which they had paid.

Table II shows loss ratios for selected companies in 1977. As noted, the national average for health insurance companies is 80 percent. Most cancer insurers return less than 50 percent of premiums to their insured. Notable exceptions are Mutual of Omaha and ITT Life which return 70 and 61 percent of premiums respectively.

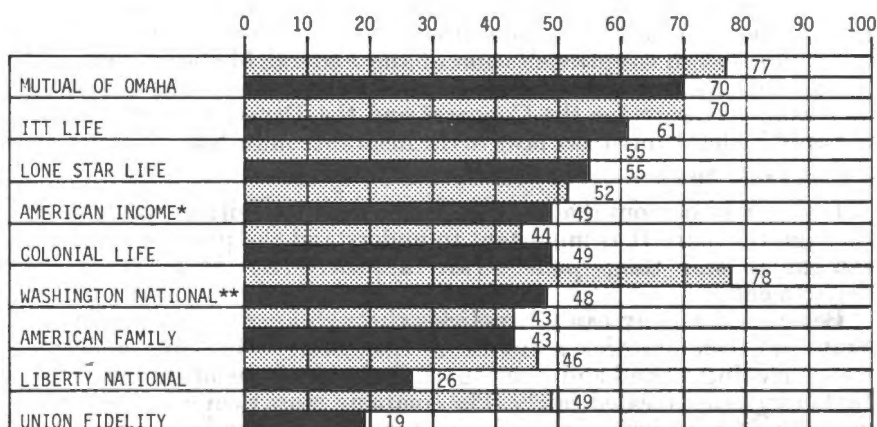


Table III shows the loss ratio experience of major cancer insurers. Both their loss ratios for all health insurance and their aggregate loss ratios on cancer insurance are indicated. As noted, most companies return far less of cancer insurance premiums to their insured than they did with their general health insurance policies.


TABLE III


RETURN ON ALL INSURANCE AS COMPARED WITH CANCER INSURANCE POLICIES

Selected Companies 1977



Source: Committee questionnaire and General Accounting Office.

 Percent of all health insurance premiums returned to insured in the form of claims.

 Percent of cancer insurance premiums returned to insured in the form of claims.

\*Indicates 1976 figures.

\*\*Figure includes cancer and other limited health and accident policies for 1976. The company dropped out of the cancer business in 1977.

### *Service versus indemnity*

The difference between indemnity policies and those which pay service benefits should be explained.

Service benefits means that the insurance company will pay for all or a percentage of actual charges unmet by medicare or by the insured's major medical coverage. Typically a company will agree through the policy to pay a percentage (say 80 percent) of covered medical services regardless of the total dollars of cost.

Indemnity policies, on the other hand, pay a flat stated number of dollars for certain health services. For example, they may agree to pay \$33 a day for hospitalization after Medicare runs out. With health care costs rising, many such policies which pay a fixed number of dollars on a daily basis do not afford much protection against inflation. Many of these indemnity policies are described in terms of giving the beneficiary "extra cash" during an illness. Their daily bene-

fit payments are promised monthly in such terms as: "Pays you \$1,000 a month." Many policies neglect to mention that their coverage does not start until the 61st day that a senior citizen is hospitalized (or later) and since the average stay in the hospital for the elderly is about 12 days, there are few who will ever collect on such policies.

Because they keep pace with inflation, policies which provide service benefits are viewed as the wiser choice for consumers.

#### *Insurance regulation by the States*

In 1945, Congress passed the McCarran-Ferguson Act which delegated to the States the authority to regulate insurance. For all intents and purposes, there is no Federal regulation of insurance although technically, the Federal government retains the right to regulate insurance to the extent that the States do not. At the printing of this report, there has been increasing pressure on the Congress to regulate insurance sold in supplementation of the Federal Medicare program in view of substantial abuses as detailed below. There has also been increasing pressure for the Congress and the Department of Justice to apply Federal anti-trust laws to the insurance industry.

#### *Policies sold by mail versus policies sold by agents*

It should be obvious that policies can be marketed either by agents or through the mail. It is important to understand the process by which companies and their policies are approved by State insurance departments.

Before a company can sell policies through agents in a particular State, it must first seek a license in that State. Obtaining a license means posting a bond and meeting all State requirements to guarantee that citizens are treated fairly. The company must then file its policies with the State insurance commissioner who reviews and approves them before they can be sold. Policies can be sold only by licensed agents. The company sponsors agents who must pass a State examination, be of good character, and sometimes post a bond themselves.

All of the above, of course, do not generally apply to mail order firms. Often they have their policies approved in one State and then send them to potential buyers in every State of the Union. The Sunday newspaper you read this week is probably full of solicitations from mail order insurers. Mail order insurers present a special problem as detailed in Section VII of this report. For years they have had a competitive advantage over other firms because they did not have to file and seek approval by State Insurance Commissioners for every policy before offering it for sale. Without the necessity to pay commissions to salesmen, profits for mail order firms are generally higher than conventional insurance companies.

#### *Commissions: How agents are paid*

Insurance salesmen, as a rule, do not receive a regular salary. They receive a certain percentage of the policy's premium. In cancer insurance sales, that premium usually is about 50 percent (sometimes more) of what the policyholder pays in premiums. This high rate of commission applies only to new sales. In case of renewals, the agent usually gets 10 percent of the premiums in the second year of the policy or thereafter. There is, therefore, a strong incentive for salesmen to make new sales in order to get the generous 50 percent commission.

## ABUSES

The commission system can lead to abuse. For example, a salesman may tell a customer that instead of renewing the policy they took last year, he has a new and better one which they should take instead. Often the only reason for the switch is to allow the agent the 50 percent instead of the 10 percent renewal commission. This abuse is so widespread in insurance practice that a name was developed for it: Twisting. Forty-four States told the Committee that this was a major problem.

The sad part about *twisting* is that it often subjects the insured to the risk of loss. It is not uncommon for policies to have a year waiting period before they will pay any claims. In the example above, the person has satisfied the waiting period and will now begin to receive protection but for the agent's intervening with his suggested "new and better" policy. The purchase of the new policy probably means the person will have to wait another year before coverage really becomes effective. If health problems develop in the meantime, the person is out of luck.

Following are other kinds of abuses sometimes perpetrated by insurance agents followed by the number of States who said they had evidence of the abuse.

**WOLF IN SHEEPS CLOTHING.**—The agent fails on initial contacts with clients to disclose that he represents a for-profit insurance company. He may say he is from Medicare and wants to help seniors with any problem they may have. *Thirty-four States indicated that they had evidence of this kind of abuse.*<sup>1</sup>

**OVERSELLING.**—The agent sells the clients more coverage than they need or can pay for or both—also known as "stacking." If you have two or more policies offering the same benefit you only get paid once. *Forty-four States reported they had evidence of "stacking" or "loading," both terms for overselling insurance.*

**LOW WEEKLY RATES.**—The agent quotes premium prices on a weekly basis but closes and sells on an annual basis. *Fifteen States responded affirmatively.*

**PIE IN THE SKY.**—(or "fine print")—The agent misrepresents policy content with words like "no waiting periods" "this policy will pay for everything," etc. *Thirty-nine States said they had evidence of agents misrepresenting policy provisions in conjunction with the sale of medicare supplementary and other health insurance policies.*

**THE SWITCH.**—The agent sells the client one policy but then switches and provides another for signature at time of closing. *Twenty-five States responded affirmatively when asked if they had evidence of this abuse.*

**POSTDATING APPLICATION.**—The agent postdates application to avoid maximum coverage guidelines. Net result is that client is often not covered for initially agreed period. *Fourteen States responded affirmatively.*

<sup>1</sup> This same type of misrepresentation occurs in the advertising materials used by some companies, particularly those that specialize in mail order sales. This was brought to the Committee's attention by Congressman John F. Seiberling (D.-Ohio). See appendix V, p. 262.

**GROUP POLICY.**—The agent represents the policy as a group policy with the implication that premiums are less, when in fact there is no group and the policy is the same in coverage and premium as a regular policy. *Twenty-one States said they had evidence of this kind of abuse.*

**THE FENCE POST POLICIES.**—The agent completes applications in the name of relatives or others, unknown to the victims. This is done to bypass underwriting rules when it is known the victims already have the maximum coverage in effect with a company. *Eighteen States said they had recent evidence of this kind of abuse being perpetrated by agents.*

**FORGERY.**—The agent either signs someone's name to the insurance forms or encourages the elderly client to illegally sign name of insured loved one. *Thirty States told the Committee that they had experience with agents forging signatures or engaging in other illegal activities such as writing fictitious policies.*

**SCARE TACTICS.**—The agent employs scare language in closing the sale like "buy now because you may not be able to be insured later," etc. *Thirty-eight States said they had evidence of agents using scare tactics in their efforts to sell medicare supplementary policies.*

**CLEAN SHEETING.**—(or "failure to report material condition")—The agent fails to report preexisting health conditions of clients to company, ultimately leading to a preexisting condition disqualification of coverage when claims are filed. *Forty-one States answered affirmatively when asked whether they had evidence of agents engaging in this abuse.*

**I WORK WITH . . .**—The licensed salesman allows an unlicensed agent to front for him. *Twenty-eight States said they had evidence of this illegal activity.*

Several States such as Minnesota, Arizona, West Virginia, New Hampshire and California responded that they had evidence of all 22 of the violations described in the Committee's questionnaire. Only Alaska and Hawaii responded that they had no evidence of any of the numbered list of violations.

When confronted with these abuses, insurance companies generally respond that the abuses are acts of individual agents acting alone and not a result of company policy. By interviewing insurance salesmen and working as trainees with several insurance companies, staff members of the House Select Committee on Aging proved conclusively that some companies in the area of Medicare supplementary insurance did actively encourage their agents to take advantage of the elderly. (See "Abuses in the Sale of Health Insurance to the Elderly in Supplemented agent to front for him. *Twenty-eight States said they had* plementation of Medicare: A National Scandal.")

#### LAX ENFORCEMENT

The natural question in the public mind is: What do the States do about these abuses? The answer apparently is very little. The Committee learned that either adequate laws and regulations were not on the books or the laws and regulations were not being enforced.

In its July 1978 questionnaire to State Insurance Departments, the Committee asked how many agent's licenses had been revoked for abuses in the sale of health insurance (an area which includes dread disease or cancer policies) and how many companies had been fined or disciplined for health insurance-related abuses. The answers were shocking.

As Chairman Pepper said in his June 13, 1979 news release:

Most States deserve poor marks. Many States reported never having disciplined an agent for abuses in the sale of health insurance in the past five years. Four States, Florida, New York, California and Virginia account for 60 percent of the license revocations over this time frame. Only 11 States have disciplined an insurance company for health insurance related abuses in the past three years. Kansas, Massachusetts and Texas lead the list.

### III. THE CHRONOLOGY OF STUDIES AND INVESTIGATIONS

The subject of dread disease insurance has been highly controversial as far back as the 1950's when the single disease being covered was polio. In the 1970's, cancer replaced polio as the disease most feared by Americans and several companies began to capitalize on that fear.

The arguments which are raised, both pro and con, have been noted earlier. Proponents claim the policies offer peace of mind. Sometimes they claim policies will pay benefits of \$150,000 or more. Confronted with evidence that average claims paid were about \$1,000, they assert that the policies are not intended to stand alone—that they are supplemental in nature but that they offer significant benefits if an individual suffers a cancer attack. They assert that all insurance is sold on fear, that they do not create the fear but merely help assuage it. Typical examples of cancer brochures are reprinted on the following pages.

The criticism implied in most of the studies and investigations to date is that cancer insurers market a product of extremely limited economic value. It is asserted that for the same amount of money a consumer can obtain a supplemental policy which covers all kinds of medical problems, not just cancer. Cancer insurers are accused of profiteering. While the average health insurance company returns 80 cents on the premium dollar to their insured, cancer insurers often return less than 40 cents on the dollar with 60 cents going to profits, commissions and expenses. Finally, cancer insurers are accused of using scare tactics to heighten the fears of consumers and then offering them the gossamer rescue of a cancer policy.

Since 1971 there have been some 25 studies or investigations of companies that sell cancer insurance. Every major study of dread disease insurance reviewed by the Committee is summarized below. As noted earlier, some 300 companies market cancer insurance but the major share of the market is held by a few companies whose names appear repeatedly in the following studies.

Almost every major study of dread disease—and especially of cancer insurance—share the following conclusions:

- Companies selling cancer insurance heighten fears in order to sell their product.
- Cancer insurance has extremely limited economic value as characterized by low loss ratios and high profits.
- The public would be better advised to expand their existing comprehensive health insurance than to buy a policy which insures only against a single disease.

**CANCER  
PROTECTION  
PROGRAM**

**CANCER... BANKRUPTS  
AS WELL AS KILLS!**

1.307-886.7 (4-77)

## FACTS AND FIGURES ABOUT **CANCER**

Compiled by the American Cancer Society

### CANCER STRIKES

- one in every four Americans
- in two out of three families
- at any age, in any group

### CANCER KILLS

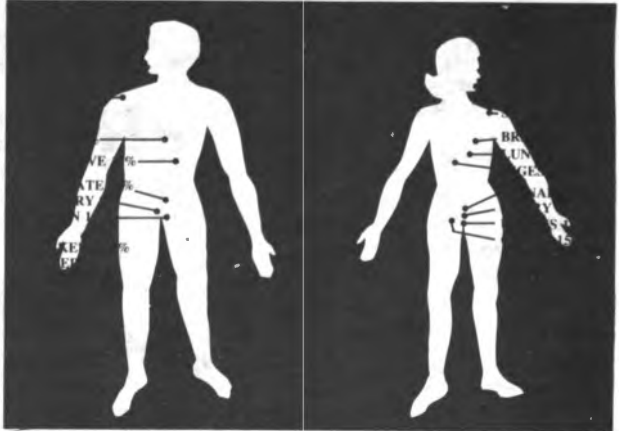
- at three times the rate of auto accidents
- one out of every six Americans
- more Americans every year

### CANCER TREATMENT

- is often in distant cities
- is often the most expensive
- is often prolonged

### CANCER CURES

- are possible in one out of three cases
- one out of two could be cured if diagnosed & treated in time
- may be increased by early detection



**THE MAXIMUM BENEFITS UNDER THIS POLICY ARE \$100,000 PER PERSON**

Amount Shown Is the Benefit for Each Insured Person

#### A. HOSPITAL BENEFIT

\$60 per day for first seven days; \$40 per day thereafter.

#### B. HOSPITAL INDEMNITY

\$7.50 for each day (\$225.00 per month) of hospital confinement beginning with the first day for up to 180 days.

#### C. ANESTHESIA

Up to \$70 for each operation. Up to \$30 for skin cancer operations. \$1,400 maximum.

#### D. X-RAY AND RADIUM

Up to \$2,000 for X-Ray, Chemotherapy, Radium, Radioactive Isotope and Cobalt (diagnostic x-ray not included).

#### E. NURSING

Up to \$30 per day, at home or in the hospital, for a Registered Graduate Nurse or Licensed Practical Nurse. \$700 maximum.

#### F. PHYSICIAN

\$10 per day, while hospitalized, for a licensed physician, other than a surgeon or in addition to the surgeon. Not to exceed one call per day. \$1,000 maximum.

#### G. BLOOD AND PLASMA

Pays the usual and customary charge, up to \$600. No limit for leukemia.

#### H. AMBULANCE

To and from the hospital where the Insured is admitted as a patient but not to exceed \$50 for each confinement. \$600 maximum.

#### I. TRANSPORTATION

Up to \$1,200 for air, rail or bus transportation from the legal residence of the Insured to and from the nearest hospital offering treatment facilities not available locally. Must be at doctor's direction.

#### J. SURGICAL BENEFITS

Pays from \$80.00 to \$500.00 according to the Schedule of Operations shown in the Policy. May be performed in hospital or doctor's office.

#### K. EXTENDED BENEFITS

For hospital confinement exceeding 90 consecutive days, the Company will pay 100% of the usual and customary hospital charges up to \$4,200 per month plus an additional \$15 per day for each day you are in the hospital, for a total of \$4,650.00 per month.

#### L. 10% NON-MEDICAL BENEFIT

The Insured shall also receive a cash payment equal to 10% of the total claim paid, that may be used at the discretion of the Insured.

#### PAYS REGARDLESS

#### OF OTHER INSURANCE

The only exception is that you may own only one cancer policy with Empire Life.

#### GUARANTEED RENEWABLE FOR LIFE

Your policy cannot be cancelled, regardless of any changes in your health, the number of times you receive benefit payments or advancing age. The only way your policy can be cancelled is for failure to pay your premium or payment by the Company of the maximum benefit. You cannot be singled out for a rate increase. The Company can only change your rate if there is a general rate adjustment on all policies of this type in your state.

**THIS IS LIMITED TO CANCER ONLY  
FIRST 90 DAYS EXPENSE \$10,000-\$4,650 EACH MONTH THEREAFTER.**

## CELEBRITIES AND CANCER

Cancer has struck many personalities of world and national fame. Such greats of stage and screen as John Wayne, William Powell, Glynnis Johns and Van Johnson have all had cancer but are alive today, cured of the disease. Other famous people alive and well after cancer include: Betty Ford, Happy Rockefeller, Shirley Temple Black and Marvella Bayh, the NAACP's Roy Wilkins, theater's Richard Rodgers and William Gargan, opera's Beverly Sills, television's Virginia Graham and Arthur Godfrey, pro-football's Jack Pardee and golf's Gene Littler.

Most people in public life are reluctant to talk about, or perhaps even think about, their personal involvement with this or any disease, so the actual records are sparse. Even among those lost to cancer the death cause is not always accurately specific, but the toll of world figures with each passing year is a dramatic reminder of the full dimensions of cancer's human devastation.

In 1975-76, these well-known people died of cancer: Sir Stanley Baker, Chou En-Lai, Percy Faith, Nellie Fox, J. Paul Getty, Anna Roosevelt Halsted, Tilly Losch, Ted Mack, Abby Rockefeller Mauze, Martha Mitchell, Lily Pons, William Redfield, Luke Short, Alastair Sim and Casey Stengel.

In 1974-75, these well-known people died of cancer: Leroy Anderson, Jack Benny, Vittorio De Sica, Susan Hayward, Fredric March, Ozzie Nelson, Charles H. Revson, Cornelius Ryan, Vincent Sheehan, and U Thant.

Among other past victims in various fields:

ENTERTAINMENT

Bud Abbott  
Tallulah Bankhead  
Humphrey Bogart  
Spring Byington  
George M. Cohan  
Eddie Condon  
Gary Cooper  
Brian Donlevy  
Dan Duryea  
Duke Ellington  
Fernandel  
John Ford  
Laurence Harvey  
Jack Hawkins  
Judy Holliday  
Edward Everett Horton  
Gene Krupa  
Charles Laughton  
Gertrude Lawrence  
Gypsy Rose Lee  
Harold Lloyd  
Anna Magnani  
Marcel Pagnol  
Zasu Pitts  
Dick Powell  
Edward G. Robinson  
Diana Sands  
Ed Sullivan  
Sophie Tucker  
Margaret Webster  
Marie Wilson

SCIENCE

Marie Curie  
Tom Dooley  
Enrico Fermi  
Irene Joliot-Curie  
Charles A. Lindbergh  
William Menninger  
Peyton Rous  
Richard E. Shope

LITERATURE

Ludwig Bemelmans  
Catherine Drinker Bowen  
Van Myck Brooks  
Rachel Carson  
T.S. Eliot  
Edna Ferber  
Erle Stanley Gardner  
John Gunther  
Lorraine Hansberry  
Aldous Huxley  
Olivier LaFarge  
Nancy Mitford  
Clifford Odets  
Edward Arlington Robinson  
Damon Runyon  
Gertrude Stein  
Jacqueline Susann

COMMUNICATIONS

Steward Alsop  
Chet Huntley  
Frank McGee  
Walter Winchell

SPORTS

Ty Cobb  
Walter Hagen  
Millie Hoppe  
Fred Hutchinson  
Frank Leahy  
Vince Lombardi  
Barney Ross  
Babe Ruth  
Casey Stengel  
Dick Tiger  
"Pop" Warner  
Babe Dridrikson Zaharias

DIED OF LUNG CANCER

Creighton W. Abrams  
Michael Arlen  
Elizabeth Bowen  
Clair L. Chennault  
Nat "King" Cole  
Walt Disney  
King George VI of England  
Betty Grable  
Buster Keaton  
Edward R. Murrow  
Boris Pasternak  
Gregor Platigorsky  
Robert Ryan  
Robert A. Taft  
William Talm  
Robert Taylor  
Francois Tone  
Jennie Tourel

Source: January 5, 1979 letter to Chairman Claude Pepper from Lewis R. Rich, President, Equitable Life and Casualty Insurance Company, Salt Lake City, Utah

# CANCER

## **CANCER:**

**...will eventually strike one in every four Americans according to present rates (approximately 54 million).**

**Approximately two of every three American families will have a case of cancer.**

**During 1976, 370,000 Americans will die of cancer, but...approximately 225,000 are alive five years after treatment.**

**One problem is the astronomical cost of treatment.**

\*All cancer statistics from '76 **CANCER FACTS AND FIGURES** published by the American Cancer Society

### 1971 NEW YORK BANS CANCER INSURANCE

In 1971, the New York Department of Insurance undertook a major study of cancer insurance which resulted in a regulation banning the sale of single disease policies in that State.

In 1972, Malcolm McKay, Deputy Superintendent of Insurance, gave an interview to the *New York Times* which underscores the depth of concern within that Department. He said:

The worst abuse in commercial health insurance in New York involved the sale of "dread disease" policies; for example, those that provide cash payments if the beneficiary develops cancer.

Raymond D'Amico, of the New York Insurance Department, told *The Capital Times* (Wisconsin), dread disease policies were banned for several reasons:

We were trying to encourage coverage of a substantive nature. And we did not feel that a policy that just covers heart attacks offers that kind of coverage.

The fear element had something to do with it too. Some of the dread disease companies use fear tactics to sell their insurance.

James Clyne, also of the New York Insurance Department said:

[B]efore the regulation banning dread disease policies was written, we administratively frowned on that kind of insurance.

We felt it was not a good bargain and created a bad situation for consumers by misleading them into thinking they had more coverage than they really did.

### 1972 INVESTIGATION BY HERBERT DENENBERG, COMMISSIONER OF INSURANCE, STATE OF PENNSYLVANIA

In 1972, the State of Pennsylvania conducted a major study of dread disease insurance under the direction of consumer advocate, Commissioner Herbert Denenberg. The study came to the same conclusions about the limited economic benefit of cancer or related policies and resulted in a ban of the product.

Cancer insurers, however, brought suit and the Court ruled that the Commissioner did not have the authority under Pennsylvania law to ban a product—he could only regulate it—that is, subject it to reasonable standards.

The result was new and tighter regulations which made it very difficult to market these kinds of policies in the State.

### 1972 HEARINGS BY THE SENATE JUDICIARY COMMITTEE, SUBCOMMITTEE ON ANTI-TRUST AND MONOPOLY

The Senate Subcommittee on Anti-trust and Monopoly conducted major hearings under the chairmanship of Senator Phil Hart of Michigan which were a landmark in the area of the regulation of health

insurance. Among other things, the hearings featured a lively exchange between Senator Hart and John Amos, president and founder of the American Family Life Assurance Company.

Amos had this explanation for the rapid growth in sales of cancer insurance:

Special risk insurance has been around since the beginning of insurance time. Travelers Insurance Company pioneered the dread disease frontier by writing accident insurance, with health policies entering the scene in 1899. Airline trip insurance is but an extension of safe voyage insurance of the hazardous sea faring days. Double indemnity is a very prevalent special risk insurance coverage which pays only upon accidental death. Dread disease supplements have been available as a Blue Cross optional coverage rider for many years. Polio insurance was commonplace in the pre-Salk Vaccine days. It parallels the concern of the times. Today cancer insurance is becoming prevalent; it reflects the public's concern about cancer. They are buying peace of mind through extra coverage.

We are not selling any broadbased policy. We are selling a policy that pays in the event of cancer. It is special, and it is a product of our history. Special risk policies sort of follow the times, and the plague of the times.

Amos' assertion that the policies offer people peace of mind led Senator Hart to respond:

Yes, I do understand. But the peace of mind you get is not that it will prevent cancer but that it will protect you and your family against the economic disaster that all of us anticipate if cancer strikes.

Amos responded:

We do not sell anything else but a financial medical supplement. But I do not buy airplane insurance because I am under-insured. I buy it because I feel like if I don't buy it this may be the very time the airplane is going to fall. I am sure this plays some part in their persistence. They bought the policy, they have carried it and they have a superstition about dropping it, I'm certain.

At these same hearings, Commissioner Denenberg appeared with harsh words about cancer and other dread disease products. He was particularly rough on such policies that are sold by mail:

There are mail order insurance companies which take all comers, but this is typically narrow if not outright "junk" insurance.

It is also unreasonably expensive in terms of benefit-cost ratio. It typically has a 2- or 3-year preexisting condition exclusion.

It is usually merely a supplement to broader coverage rather than a basic comprehensive form of protection. These companies don't serve the entire market, but typically render a serious disservice to the insurance buyer.

The dread disease policy is perhaps the classic example. These policies may cover only medical expenses for polio, cancer, heart transplant or other combinations of dread diseases. They can be marketed at what seems to be a low premium, because it is geared to return only a small percentage of premiums in benefits.

Another standard term in the hucksters bag is the hospital supplement which pays a specified daily amount if and only if the policyholder is in the hospital.

We would like to see about six standard policies and the disappearance of the gimmick, Mickey Mouse, junk and, narrow coverage health policies which now pervade the health insurance market.

Denenberg added :

There has been much talk lately about the inefficiencies of our auto liability insurance system because it returns only 42 cents of each premium dollar in benefits. The Pennsylvania lottery does better, returning 45 cents in benefits to the public.

Individual health insurance is not much more efficient than the very model of inefficiency—the auto liability insurance system.

The cost-benefit ratio for many individual contracts is less than 50 percent . . . Some policies are returning as little as 5 to 10 percent of premiums in benefits to policyholders. Some types of policies, such as the cancer policy, typically return 30 to 40 percent of the premiums in benefits to policyholders.

Individual health insurance companies are burning up about a billion dollars a year in advertising and administrative expenses.

The public thinks it's buying medical care. In fact, it's pouring about half its spending on individual contracts into the excessive expenses of the commercial health insurers.

### 1972 "THE HEALTH INSURANCE BOOBY TRAPS"

By Commissioner Denenberg

Writing in *The Progressive*, Commissioner Denenberg had similar things to say about single disease policies :

Some policies—known as dread disease policies—are so narrow in coverage they pay if and only if you get a certain disease. Usually the disease covered is cancer. Sometimes the policies include other "dread diseases" such as leukemia, spinal meningitis, rabies, polio and the like. While not all limited disease policies are exactly alike, none gives you the broad coverage you want and need. When you buy these policies, you're not insuring, you're gambling.

Writing about companies which make sure that premiums are "eaten up in expenses and profits," he said :

A clever company can establish the ultimate in low return—a "dread disease" policy that returns only 7 cents on the

premium dollar. It would seem that the public would be too smart to fall for such a fraud, but millions of policyholders are paying premiums each year for such policies.

#### 1972 NEW HAMPSHIRE DEPARTMENT OF INSURANCE BANS CANCER INSURANCE

In 1972, the New Hampshire Department of Insurance conducted its own investigation which resulted somewhat later in the State not allowing the sale of dread disease policies. The following reasons were given as justification for this action :

(1) By its very nature, such a policy invites a sales pitch based unduly on fear.

(2) Of 28,070,000 hospital discharges in the United States in 1968, malignant neoplasms (cancer), constituted the diagnosis in 1,044,000 cases, or 3.7 percent. (Page 1166 of Hearings before Subcommittee on Antitrust and Monopoly, Part 1A, May and June, 1972).

The average length of stay for cancer was 15.3 days, significantly above the average of 8.5 days, but less, for example, than heart attacks—18.8 days.

The point is that the risk is very low but people, out of fear, may buy a cancer policy to the exclusion of coverage for the other 96.3 percent of hospital admissions.

(3) The incidence of cancer, like death, increases with age. This raises the question of whether cancer policies should have nonforfeiture values.

(4) New York State banned cancer policies; other States have refused to approve them.

(5) Considering the companies in this business, it is doubtful any cancer policies could meet our minimum 50% loss ratio test.

#### 1973 INVESTIGATION BY THE STATE OF KANSAS

An investigation by the Kansas Insurance Department led to a fine levied against the Old American Insurance Company for advertising benefits which were illusory. According to the cease and desist order which was filed in the case, the company was asserting (among other things) that both the insured and the spouse would be covered when, in fact, only single coverage was being offered.

#### 1976 CONNECTICUT BANS DREAD DISEASE INSURANCE

The Connecticut legislature banned the sale of cancer and other dread disease insurance because the Department of Insurance study disclosed that policies do not provide dollar value for premiums paid by the policyholders. Officials said that many people were being misled into thinking that they were buying broader coverage when they were buying a policy that would only pay in the case the individual contracted cancer.

## 1976 NEW JERSEY BANS DREAD DISEASE POLICIES

After an extensive investigation, the New Jersey Insurance Department banned dread disease policies on the grounds that such policies had limited economic value, contained misleading information and were unfair and inequitable to the extent of being contrary to the public policy of the State.

## 1976 INVESTIGATION BY THE MADISON, WISCONSIN CAPITAL TIMES

On April 12, 1976, the *Capital Times* released the results of their extensive investigation of cancer insurance. The *Times* found that about 30 firms sold cancer insurance in Wisconsin although not all of them actively. The *Times* focused on several companies but was particularly impressed by the American Family Life Assurance Company which sold some 9,000 policies in the State in 1971, with more than 70,000 being sold in 1975. In all, a quarter of a million policies had been sold in the State by AFLAC during 1970-1975.

The *Times* said this growth had not been without its problems: It said complaints on file with the State insurance commissioners indicated that AFLAC salespersons have on occasion:

- Been suspended by the company for not passing along premium payments to the home office.
- Claimed a group's or company's endorsement of AFLAC's cancer policy when no endorsement existed.
- Failed to note subscribers' previous history of cancer when subscribers have volunteered the information to agents.
- Gone into communities dropping names of persons who have the cancer coverage, without first getting permission to use the names.
- Sold two, nearly identical policies, to an elderly man.
- Acted as representatives of the company without proper State insurance licenses.
- Attempted to sell to state employees against the wishes of the State Group Insurance Bureau which oversees such payroll deduction transactions for state workers.

Following are excerpts from the *Times* story:

When complaints do come, they often stem from the elderly or from the relatives of an elderly person.

In 1975 the company estimated that about 60 percent of its state business (in which agents sold to individuals and not through groups or companies) was with persons over 55. Through groups and companies, about 22 percent were with persons over 55.

What follows are some case studies of official complaints.

An Eau Claire man in 1974 complained that his mother had purchased a cancer policy "when she was in no condition to make such a decision to purchase. But she did" and then never received her policy or premium.

It turned out the agent never forwarded the premium payment to the home office in Georgia. Having investigated the agent, the company found several other instances of such misbehavior. The company suspended the agent.

The company investigated this 1973 claim and found 15 persons in all from whom the agent had collected premium payments, cashed their checks and never sent the applications on to the home office.

The 15 were contacted and their policies issued despite the agent's original failure to transmit the premium payments. The company then withdrew the agent's license and certificate of registration.

There also have been cases where agents did not record all pertinent medical information of applicants with previous cancer history. Had this gone unchecked, the policy may have been worthless if cancer were contracted and a claim submitted. An elderly Cedarburg woman explains why, in her complaint.

"I saw that on the original application the agent wrote, he had crossed out the fact that I had cancer 20 years ago.

"According to my insurance policy, omissions or misstatements in the application could cause an otherwise valid claim to be denied. The only misstatements made on the application were deliberately made by your agent," she said.

The company refunded the woman's policy and the agent told the state the whole matter was "negligence on my part."

The *Times* continued:

In a similar case, a Cumberland woman complained last year that her mother was sold a policy just three years after she had had cancer. She told the agent this, yet, the woman said "(the agent) put none (in the blank for previous cancer history) on the application."

AFLAC vice president Frank L. Kimbrough told the woman her mother's application "was completely mishandled." Her mother's premium was refunded.

Documents also show that an agent said his company was endorsed by a group when in fact no such endorsement or sponsorship had been made. Instead he had received only written permission to solicit group members.

The case in point involves AFLAC and the Stoughton Hospital Auxiliary in 1973.

The agent received permission from the auxiliary president to solicit membership. With this permission the agent was given the auxiliary's membership list. But when selling the policy, the agent referred to solicitation authority as endorsement—which it clearly was not.

A complaint was filed in the case, prompting both the auxiliary and Stoughton Chamber of Commerce to place newspaper ads disavowing any endorsement of cancer insurance.

The company checked up on the agent and agreed he did "misquote the sponsorship."

He was advised not to use the words endorsement or sponsorship unless he had such things in writing.

Documents also show agents have, on occasion, gone into a community and dropped names of residents—without those residents' permission—in order to sell policies.

One such case involved a Barron County family in which the husband—insured by AFLAC—had died of cancer. After the man's death, agents for the company used his death to try to sell insurance, showing how the company paid off such claims.

They did this, however, without the family's approval.

The family eventually learned of this and asked agents, through an attorney, to cease this practice.

When brought to the attention of both the state office and the Georgia home office, the company investigated and told the state its agents used poor judgment in the matter.

In a similar case, a Wisconsin man said an agent attempted to sell his elderly aunt a policy and told the woman he was acquainted with her nephew. The nephew, upon hearing this, complained to the state that he did not know the agent and had never met him.

An elderly Fond du Lac County man told *The Capital Times* he was sold two nearly identical policies in different years by AFLAC agents. He said he didn't realize this until a third agent, from a different company, visited him trying to sell a policy.

When he brought out his two cancer policies, the third agent told him he had essentially duplicate policies. An anonymous letterwriter pointed this out to the state, which in turn questioned the company. AFLAC agreed to cancel the second policy, apply money that had been paid for the extra policy to the renewal of the original one. The man was satisfied.

Moreover, the *Times* added :

In two 1972 instances, agents for the assurance company were discovered by the state to have sold without proper licenses.

Wisconsin statutes point out it is unlawful for any person to act as an agent unless he holds an agent's license and certificate.

The state, in one of these cases, informed the company that the agent had sold more than 100 policies without proper authorization. The company checked it, agreed and apologized to the state, saying the error was an honest misunderstanding.

In the other case, a young AFLAC agent was confronted by the state for selling without a proper license and ordered to appear before an official of the state insurance commission.

The agent told the commission that he had been misled by another company agent and was unfamiliar with the law.

The state warned the agent but took no formal action against him. Since then, there are no reported cases of company agents having sold without licenses.

But there has been another run-in with the state: this time over a 1975 complaint. The complaint came from Dale Hanson, director of the State Group Insurance Bureau, which approves payroll deduction plans for state employees.

Hanson told the state insurance commission that agents for the Georgia firm had been trying to sell insurance policies to state employees in the Waupun area.

He also said agents incorrectly had told state employees the plan was approved for state employees and authorized for payroll deductions.

Hanson went on to say the company did not have this authority and never had authorization from the State Group Insurance Board. In fact, he said, on June 13, 1972, the AFLAC cancer program was turned down by the board as an eligible payroll deduction plan.

The company responded, saying the whole thing was a misunderstanding. An AFLAC official said the firm received a solicitation authority code from the state on April 17, 1972, (two months before the SGIB rejected the plan) and because of this the firm reasoned it had at least received "implied" permission to solicit state employees.

The state disagreed. And the company now has asked its agents to discontinue soliciting state employees.

Representative Joseph C. Czerwinski of Milwaukee wrote to the State Insurance Commissioner protesting against some of the advertising material used by cancer insurers. "It is often the most unsuspecting people such as the elderly that get 'taken in' by such policies," Czerwinski said.

He continued:

It is my hope that we will eventually outlaw the sale of dread disease policies in this state. Not only do we have Wisconsin citizens purchasing often needless coverage based on some phobia, i.e., cancer; but also purchasing coverage for diseases in which the probability of contracting such disease is highly improbable.

The *Capital Times* also quoted Dale Turley of the Illinois Insurance Department as saying dread disease policies were "very profitable." The *Times* made reference to loss ratios as an index of both profitability and economic benefit to the consumer. Quoting Commissioner Denenberg, the *Times* said a high loss ratio means good value for the consumer. Blue Cross/Blue Shield and other commercial insurers commonly return over 90 cents on the premium dollar back to their insured. Most dread disease companies are well below 50 percent, said the *Times* which developed the following table:

TABLE IV.—MAJOR CANCER INSURERS IN WISCONSIN<sup>1</sup>

Insurance company	Premiums earned (1974) from cancer policy	Losses incurred (1974) from cancer policy	Loss ratio (1974) from cancer policy (percent)	Total premium income rank (1974), all policies	Best's policyholders recommendation (1975), all policies
American Family Life Assurance Co. of Georgia. <sup>3</sup>	\$48,700,000	\$18,700,000	39	111	None.
Bankers Life and Casualty <sup>3</sup>	( <sup>4</sup> )	( <sup>4</sup> )	( <sup>4</sup> )	22	Substantial.
American Heritage	243,383	60,282	24.8	125	Do.
Federal Kemper	7,690	740	9.6	353	Do.
Great American Reserve	71,994	26,534	36.8	188	Do.
Guarantee Trust	61,020	32,886	54	184	Considerable.
Gulf Atlantic	51,064	15,326	30	398	Do.
Illinois Mutual	121,706	82,745	68	233	Substantial.
Inter Ocean	293,529	104,814	35.8	181	Do.
ITT Life <sup>3</sup>	1,400,000	451,068	32.4	155	Considerable.
Kentucky Central	330,524	112,712	34.1	129	Substantial.
Lone Star <sup>2</sup>	1,880,000	640,890	34	208	Considerable.
Medico <sup>2</sup>	345,752	86,244	24.9	( <sup>4</sup> )	None.
Mutual Protective <sup>3</sup>	1,100,000	260,698	23.54	( <sup>4</sup> )	Do.
National Ben Franklin Life	522,674	323,052	61.8	278	Substantial.
Reliable Life & Casualty	33,978	8,433	24.8	( <sup>4</sup> )	None.
Reserve Life <sup>3</sup>	1,600,000	744,974	46.2	85	Substantial.
Union Fidelity <sup>2</sup>	( <sup>4</sup> )	( <sup>4</sup> )	( <sup>4</sup> )	216	Do.
Loyal American	( <sup>4</sup> )	( <sup>4</sup> )	( <sup>4</sup> )	458	Considerable.
Independence Life & Insurance Co.	( <sup>4</sup> )	( <sup>4</sup> )	( <sup>4</sup> )	404	Very substantial.

<sup>1</sup> Here is a list of insurance companies selling cancer policies and licensed in Wisconsin. They are listed by: name, the amount of cancer premiums earned nationally in 1974, cancer losses incurred that year, loss ratio, the 1974 rank of its premium income (not restricted to cancer sales only), and its policyholder recommendation rating by the A. M. Best Co. The cancer sales figures are based on national sales and are provided by annual statements sent by the insurance companies to the nation's 50 insurance commissions. The total premium income figures are supplied by the A. M. Best Co., in its August 1975 Life/Health Magazine. The chart's policyholder recommendations are established by the A. M. Best Co., a privately owned New Jersey firm specializing in monitoring trends in the insurance industry and determining ratings of insurers. Recommendations for life/health companies span from no recommendation, to "considerable," "substantial," "very substantial," and "most substantial."

<sup>2</sup> Designates those companies actively selling cancer policies in Wisconsin. Other company names include firms with cancer policies (based on the 1975 edition of "Who Writes What in Life and Health Insurance," published by the National Underwriter Co.) and which are licensed in the State of Wisconsin (according to the State insurance commission).

<sup>3</sup> Not available.

<sup>4</sup> Not in top 500.

<sup>5</sup> Unknown.

Source: Capital Times, Apr. 12, 1976.

The *Times* noted that dread disease policies were also under fire from insurance companies. Robert L. Curry, President of Cuna Mutual Insurance Society of Madison, Wisconsin was quoted as saying his company<sup>1</sup> refused to sell dread disease policies. He resisted requests to sell cancer insurance, the *Times* reports because "in our opinion such policies are of such limited value and such restricted benefits that they do not contain the desirable elements of insurance."

### 1976 TRADEMARK CONTROVERSY

On this same date the *Times* also reported a dispute between American Family Life Assurance Company and a non-profit agency over the use of a trademark. The *Capital Times* reported:

A New York City non-profit agency which assists terminally ill cancer patients and their families is upset that its registered trademark is being used to sell cancer insurance in Wisconsin and other States.

Cancer Care Inc., the New York City-based agency, told The Capital Times that the American Family Life Assurance Co. of Columbus, Ga. is "confusing the public" by using the term "Cancer Care" in its sales and advertising promotions.

The insurance company is the world's largest and most successful cancer insurer, selling in 47 states and several foreign countries. The New York City agency counsels advanced cancer victims and their families in a 50-mile radius of the city.

The U.S. Patent Office told The Capital Times that "Cancer Care" is the registered trademark of the New York agency and not of the Georgia firm.

The search division of the Patent Office said the Georgia company's registered trademark is the letter "C" inside of which is a family symbol.

"Cancer Care" is not registered to the Georgia firm, the patent office said.

"The American Family Life Assurance Co. of Columbus, Ga., is confusing the public in the use of the name 'Cancer Care,'" remarked Irene G. Buckley, executive director of the New York charitable group.

James Graham, an AFLAC senior vice president, told The Capital Times recently to "please be assured that in no sense are we trying to trade in or cash in on their name," speaking of the charitable group.

He said the New York agency is not an insurance company, is operating only in a limited area while AFLAC is nationwide. "We are talking on a very friendly basis" with them about the trademark situation, Graham said.

Graham and his company had never heard of the New York firm until the trademark search process began and it was pointed out another agency had beaten them to the name "Cancer Care."

"Yes, there is a company in New York that goes by the name, "Cancer Care, Inc.," no, there is no connection between the two of us. And yes, we are working for a resolution of the problem," Graham summarized.

"We do not feel that by offering an insurance policy we are in conflict with them," Graham added.

Joe Kuechenmeister, Wisconsin state manager of the insurance company, said the "Cancer Care" term is used here in order not to confuse his firm's longer name with the American Family Life Insurance Co. (a Madison-based company).

The New York City agency, nonetheless, finds the use of its trademark "troublesome," said Zita Walsh, a spokeswoman for "Cancer Care, Inc."

The charitable agency said it wishes the assurance company would drop the term because it doesn't wish to be associated with the firm.

"We do not endorse their product; we would never endorse such a thing," executive director Buckley said.

She previously has been critical of insurance companies that sell dread disease policies. She told the House Ways and Means Committee in 1974 that a "disease-by-disease

categorical approach oriented to catastrophic illness is unsound, impractical and uneconomical."

Representatives of the New York agency have consistently testified before congressional subcommittees in favor of national health insurance to cover extravagant costs associated with catastrophic diseases such as cancer.

#### MARCH 1, 1977, FORBES MAGAZINE

*Forbes* Magazine completed a profile of American Family Life Assurance Company saying "the company is being hailed by its boosters as the fastest growing insurance company in the world."

The magazine quotes AFLAC President John Amos:

We provide a valuable service to policyholders who have a claim. For those who don't have a claim, well, I guess we'd have to confess to being a ripoff. Just the way that fire insurance is a ripoff for anyone who doesn't have a fire.

*Forbes* notes that unlike fire and casualty companies, AFLAC does not have any competition, writing about 60 percent of all cancer policies sold in the U.S. *Forbes* quotes Amos as saying that while it takes seven years to break even with life insurance, he breaks even with his cancer policies inside of two years. As for the explanation, *Forbes* says:

American Family is a hard-sell merchandising company that just happens to sell insurance. . . . Amos also convened an aggressive sales force so well paid and rewarded that the company will never be licensed in New York or New Jersey which have strict limitations on agent commissions and sales contest prizes and specific bans on dread disease products.

*Forbes* notes that despite extensive growth in sales, American Family has not attracted institutional investors. *Forbes* guesses that the demise of Equity Funding has made investors wary of unknown regional insurance companies.

*Forbes* summarizes that from the policyholders point of view, "the CancerCare policy is not a bad deal—provided he or she understands that some States prohibit collecting on overlapping policies." *Forbes* also concludes that American Family's rates are too high. "American Family returns only 56 cents on the premium dollar to policyholders. An average claim runs just \$1,600 and some 25 percent of the claims are for skin cancer, a relatively inexpensive disease."

*Forbes* quotes Amos as being unconcerned about the fact that other insurers may move into the market:

We could always do something else. Sell life insurance like nobody ever sold it before. Or maybe cosmetics. We've got a heck of a sales force.

#### APRIL 24, 1978, FAMILY CIRCLE

*Family Circle* magazine ran a couple of paragraphs with the latest cancer statistics. The article mentions American Family Life Assurance Company and suggests that cancer insurance is "worth looking into."

The article brought an angry response from consumer groups, including the Center for Public Representation of Madison, Wisconsin whose staff attorney, Mary M. Bach, wrote to the editors as follows:

We are outraged by both the form and the substance of the (April 24) article and concerned about its potential impact upon readers.

We believe that your readers, and consumers generally, deserve and expect more professional journalism than this article exhibits. First, it is unclear whether the article was an advertisement for a specific insurance company, an endorsement for this company's cancer insurance by your magazine, or news reporting by a member of your staff. If the article was an advertisement or an endorsement, it should have been clearly labeled as such in order to put readers on notice that what they were reading was not objective reporting. If it was a news item, we believe that it presents a clear case of careless journalism. After reading the article one could easily be left with the mistaken impression that one should buy this insurance in order to avoid being wiped out by cancer medical bills and/or that one should buy this insurance simply because it is the latest thing in insurance coverage. Allowing either one of these inferences to be drawn is irresponsible, but allowing both is outrageous. Furthermore; quoting the American Cancer Society and the president of a specific insurance company in the same breath is misleading at best. The American Cancer Society has absolutely no connection with the sale of private cancer insurance.

We strongly suggest that a member of your staff do some in-depth reporting on the issue of cancer care and other dread disease policies, and that you feature a considered and informative article on the subject to correct any misimpressions that resulted from your April 24th article. To help you begin this project, we would like to give you some information that could be useful.

1. Buying a cancer policy is much like buying a lottery ticket. The value of such coverage depends on the chance that one will contract the disease. If one buys cancer insurance, it would follow that heart disease insurance, arthritis insurance, etc., should also be purchased.
2. Cancer insurance covers only a small portion of cancer-related medical bills. A typical policy, issued by the company referred to in your article covers only \$50 per day for the first seven days of hospital confinement and \$30 for each day thereafter. The same policy pays according to a stringent schedule of benefits for surgery, attending physicians' fees, drugs, etc. The maximum payment for X-ray, radium, and cobalt therapy, for instance, is \$1,000 per lifetime of the insured. In order to gain any coverage, malignancy is required, so that in the case of a benign tumor, coverage for surgery and other medical expenses is denied.

3. Many other health insurance policies cover the same costs as a cancer policy, but in addition insure people against the costs of other illnesses. It is nearly always best to purchase one good comprehensive hospital-surgical policy than piecemeal insurance which covers only a specified disease or pays only a fixed amount per day of hospital confinement.
4. Much of the cancer insurance sold in Wisconsin, and perhaps elsewhere, is sold to senior citizens who need insurance to supplement Medicare. Cancer insurance is not an adequate substitute for the broader health care protection provided by a policy specifically designed to fill in the gaps in Medicare.
5. The company mentioned in your article has four cancer policies approved for sale in Wisconsin. The policy with the highest sales in 1976 returned less than 21 cents in benefits for every dollar of premiums paid. Fifty-seven percent of the total premiums was paid out in commissions to agents. This is a pretty good indication that consumers are not getting what they are paying for.

JUNE 1978, CONSUMER REPORTS

Consumer Union which publishes *Consumer Reports* completed a detailed analysis of several cancer insurance firms and published the results in an article entitled, "Cashing In On Fear: The Selling Of Cancer Insurance."

The report makes the following points:

- A number of insurance companies are using fear of cancer to build one of the fastest-growing businesses in the country. "Cancer will strike one in every four Americans, two of every three families," one company's brochure points out, "If the doctor told you that you or a member of your family had cancer . . . it would take thousands of dollars for cure . . . on what bank would you draw the check?" asks another company's brochure.
- Such ads, designed to kindle the fear of cancer and its costs, do draw attention to a terrible problem. But they don't say much about a proposed solution. That cancer is costly is as true as that a hurricane is windy; average medical costs associated with treatment of cancer other than skin cancer come to about \$20,000. The question is whether cancer policies offer more protection against those costs than an umbrella does against the winds of a hurricane.
- *Consumer Reports* notes that the insurance is a good product for sellers noting rapid growth rates and profits for several companies. However, the publication has grave questions about whether the product is good for buyers.
- *Consumer Reports* says the consumer is better off on improving one's comprehensive health insurance policy than buying cancer insurance. For about the same or a little more money than it takes to buy a cancer policy, the individual can obtain a supplemental policy which helps to defray very high medical bills no matter what the medical diagnosis.

- The magazine quotes Howard Winklevoss, Associate Professor of Insurance at the Wharton School of Economics as saying that cancer accounts for only about 10 percent of all medical costs. "If you have good medical insurance, you don't need cancer insurance. If you care to spend more money you should improve your basic or major medical insurance. Cancer insurance is as close to being a worthless product as you can find. It really is an embarrassment to the insurance industry."

*Consumer Reports* concludes:

**The cost of cancer treatment is often fearfully high. Nevertheless, we don't recommend buying cancer insurance. The cancer insurance policies CU examined offer only fragmentary protection against the cost of treatment. And they offer no coverage at all for numerous other diseases that can also be expensive to treat. On balance, CU thinks any money spent on cancer insurance would be better spent on improving your broad health insurance coverage.**

*Consumer Reports* analyzed the benefits of five major companies noting that "in most of the policies, the hospital bill benefit for stays shorter than 90 days is extremely skimpy." Most policies cover less than a third of the cost. On the other hand, policies will pay nearly all the charges for a hospital stay over 90 days, and yet less than 1 percent of the population will ever be hospitalized for more than three months. "We were also struck by some other limitations," adds *Consumer Reports*. Four of the policies (Mutual of Omaha's was the exception) cover doctor's bills only when a patient is in the hospital . . .

Premiums for all five policies are subject to "change by class." That means the company can't increase the premium for an individual buyer who gets cancer, but can raise the premium rates on all cancer insurance policies at its discretion, to the extent that state regulators permit.

*Consumer Reports* tried to find out what each of the policies would pay in a typical case:

A hospital stay of 40 days would be more catastrophic, financially, costing perhaps \$8000. Yet only two of the companies—Mutual of Omaha and Union Fidelity—would cover more than one-third of the cost. Here are the five policies, a typical annual premium, and how they'd pay out on a hospital bill of \$8,000:

Company and policy	Annual premium <sup>1</sup>	Payouts
Mutual of Omaha, form 50 CL/CLF, series 8983	\$30	\$5,150
Union Fidelity Life Insurance Co., form 1-2140	75	3,480
American Family Corp., form A-6925	50	1,840
Colonial Life & Accident Ins. Co., form 0610	27	1,840
Lone Star Life Ins. Co., form SPC GR 100-CAL(73)	44	1,560

<sup>1</sup> Premium given is for a 35-yr-old single woman buying an individual plan. Group rates are generally somewhat lower, family-plan rates are generally somewhat higher.

JULY 1978, FEDERAL TRADE COMMISSION

The July 1978 report of the Federal Trade Commission had similar comments for indemnity and dread disease policies:

Both indemnity and dread disease plans will pay benefits in addition to medicare and any other private insurance, giving "extra cash." However, these policies often produce few benefits in relation to the amount of money invested; they typically have very low loss ratios.

OCTOBER 1978, INVESTIGATION BY THE OHIO ATTORNEY GENERAL

Following is the text of a memorandum from Attorney General William J. Brown to all State employees on October 30, 1978:

During this summer, our office conducted an investigation into the benefits derived by persons purchasing cancer insurance from the American Family Life Assurance Company (AFLA) through the payroll withholding plan. Our investigation found that the AFLA policies provide little additional benefits over existing State hospitalization and disability plans. We also found that the claims made by AFLA in selling their policies were exaggerated and that more comprehensive coverage could be purchased for the same or lower cost.

As a result, I requested that the Department of Administrative Services withdraw withholding privileges to AFLA as of the November 30, 1978 pay period.

On the same date, the Attorney General sent the following memo to Richard D. Jackson, Director of Administrative Services:

The American Family Life Assurance Company of Columbus, Georgia (AFLA) has been marketing and selling to employees of the State an insurance policy that provides hospitalization benefits to those persons who contract cancer during the period of coverage. Payment for the policy is made through a monthly payroll deduction.

The cancer insurance coverage sold by AFLA covers only one disease, cancer. The policy provides for certain benefits to the insured only during a time he or she is *hospitalized* with cancer. This is an important limitation on coverage because much cancer treatment is on an out-patient basis.

Cancer insurance or dread disease coverage, as it is sometimes called, has been criticized by both consumer advocates and insurance experts. A spokesperson for the American Cancer Society has stated that the Society discourages the purchase of cancer insurance and also objects to the use of its figures to sell these policies. They say that the figures are accurate but that salespeople often use them out of context. For example, when a salesman states that cancer will strike one out of every four persons, he does not say that this figure includes many kinds of curable cancer, some of which do not involve costly treatment.

The National Cancer Foundation, a social service agency in New York City which provides professional counseling and care at home for advanced cancer patients and their families, has criticized any disease by disease approach to health insurance. It found that most cancer policies provide no coverage for care at home where substantial costs, such as housekeeping, nursing and medicine are incurred. The Foundation has also observed that some policies are carefully worded to minimize hospital and physician benefits. This is true of the AFLA policy. For example, AFLA provides payments for hospital chemotherapy but not for out-patient chemotherapy. Additionally, there is even a dollar limitation on the hospital treatment.

More disturbing, AFLA's generally skimpy coverage does not match existing State programs. For example, the group Blue Cross plan already provides all the coverage supplied by AFLA's offered policies. In fact, not only won't the AFLA policies provide additional coverage for medical costs, which is the primary reason listed for obtaining the insurance, but AFLA will not even provide the double coverage to members of our group Blue Cross program. Under the coordination of benefits clause of the group Blue Cross program, for every dollar provided by another medical insurance company, group Blue Cross reduces its payment one dollar. In other words, for any of our employees who belong to group Blue Cross the additional premiums paid to AFLA buys no additional medical coverage. I might add that most of our employees do participate in Blue Cross plan.

AFLA representatives were contacted and questioned on coordination of benefits. AFLA representatives agreed that if Blue Cross coordinated benefits, their cancer policies would be of little benefit, but they claimed that a special rider had been attached to the master policy converting the AFLA cancer policy to disability insurance in the event of coordination. Unfortunately, the agents did not have a copy of the rider and previously had not filed a copy with the personnel department.

The Company subsequently mailed a copy of the rider. The rider provided that if a beneficiary was eligible for medical benefits and was being subject to coordination of benefits, the AFLA medical benefits would convert to disability benefits based on a flat fee per day of hospitalization. Although, the AFLA rider refers to those payments as 'disability' they are contingent upon hospital confinement when cancer has been officially diagnosed. Currently, the State provides a true disability coverage for those who cannot work for any reason, including those confined to hospitals with cancer. The State retirement fund, however, does not supply 100% of salary for those disabled. An employee can purchase coverage up to 100% of salary for a modest premium from a private carrier. For example, a 30 year old employee making \$8,000 can get 100% disability coverage for less than the AFLA cancer premiums.

If it appears that AFLA premiums provide little in the way of benefits, last year's cost/benefit figures filed by AFLA with the Ohio Department of Insurance confirms that appearance. For health and accident benefits AFLA paid out in Ohio only 40% of the premiums it collected in the State. This compares with 90% of premiums paid out by Blue Cross. Nor was last year in Ohio atypical for AFLA. Failure to pay out benefits, high commissions and unconscionable dividends (AFLA is a stock corporation) caused the States of New York, New Jersey and Connecticut to ban AFLA and other cancer insurance policies within their respective States.

I am not recommending a State wide ban or administrative action against AFLA at this time. However, in light of AFLA's failure to dovetail with existing State programs and its poor benefits record, I do recommend that the free use of State facilities (payroll withholding) (See Ex.B), and the implied State endorsement in AFLA's promotional material be terminated at once.

#### NOVEMBER 1978 REPORT BY THE HOUSE SELECT COMMITTEE ON AGING

In its investigation of abuses in the sale of Medicare supplementary health insurance policies, the House Committee on Aging learned that senior citizens were being sold multiple, unneeded, duplicative and therefore worthless insurance policies. While focusing on Medicare supplemental insurance, it was discovered that senior citizens were also being sold cancer insurance plans. For this reason, the Committee undertook an examination of dread disease insurance.

In its report, "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal," the Committee devotes about 40 pages to the subject of cancer insurance with the understanding that the operations of one company, American Family Life Assurance Company, had been reviewed and that an in-depth examination of the topic was necessary.

Conceding that cancer is an expensive disease and that the fear of cancer is real, the report sets forth the major questions to be examined:

Do cancer policies provide the policyholder with much protection? Are these kinds of policies a good buy? Do the companies which sell them employ the scare tactics to get people to buy? The industry response would be that the people are already frightened. Consumer advocates argue that the policy is shrewdly tailored to focus attention and exacerbate existing fears.

Following are the relevant portions of the Committee's report:

*Not IF, but WHEN you get cancer . . .*

To find out just how a company markets a cancer insurance policy, Kathleen Gardner, a committee staff investigator, secured a position as a trainee with the Maryland office of a company which is reported to be the number one seller of cancer insurance, and reported by many as the fastest growing insurance company in the world today. Ms. Gardner

attended four training sessions, obtained sample policies and company brochures, and accompanied the Maryland State Manager of the company to see firsthand how a cancer insurance pitch is made to two elderly women.

After evaluation, it was clear the basic sales presentation for the company cancer policy is designed to frighten and upset people regarding cancer and its costs—and to create a solid platform for agents to sell the cancer program. The trainee was informed that this presentation should be preceded with the phrase “when you get cancer (not if you get cancer) this policy will provide . . .” The following presentation used in Maryland is typical of an agent’s pitch to a prospective client and serves to establish the need for the cancer insurance program:

“I know I don’t have to tell you about cancer and how widespread this disease is, but did you know that individual and group hospital plans, even with major medical, may not fully cover or even come close to covering the tremendous costs of cancer?

“I don’t know if you saw the Sidney Cutler report or not, but it pointed out that cancer was so uniquely expensive today that approximately only 40 percent of the costs of cancer were borne by the best in unlimited hospital and major medical plans. The reason wasn’t because major medical didn’t do its job, it did! But they discovered that many if not most of the costs of cancer today may be non-medical. In other words, they have nothing to do with hospitalization coverage at all.

“For example, we know that today is the age of specialization, particularly in cancer treatment. Let’s say that a doctor diagnosed one of your family as having cancer. He may recommend that your best treatment would be at the Anderson Clinic in Dallas, or the Mayo Clinic in Minnesota, Sloan-Kettering in New York or locally at Johns Hopkins Leukopheresis unit where the semiprivate room rate is \$461.71. If you have to fly, your transportation costs are yours. You may be there for 2 or 3 weeks for treatment. Your hotel and meal costs may be yours. When you return, you may need additional cash for private nursing. In the meantime, you may have suffered from the largest non-medical expense—loss of income, which may be permanent with a cancer illness. Meanwhile, your regular living expenses and bills have to be paid.

“The key to our cancer program is that unlike your present hospitalization that pays the hospital and doctor directly for the bills you incur there, we pay directly to you in addition to any other insurance so that you may not only meet bills that may not be covered under major medical, but more importantly to provide the additional cash you may need to meet the nonmedical expenses of cancer like transportation and loss of income, etc.

“Now here in Maryland where we have 4 million people, we know that 1 million of us will have cancer during our

lifetime. And, of course, here on (name of prospect's street) 2 out of 3 families will be affected by this dreadful disease. And in children where we used to think of general accidents or crib deaths as being the leading cause of death, today it's leukemia. This disease (which is cancer), is now the leading cause of death in school age children. The treatment time for this disease used to be only 3 months, but today, it is over 5 years, hence the tremendous increase in treatment costs. And, of course, Mrs. ——— as you well know cancer is the leading cause of death in women age 30-54, primarily because of breast cancer. And 54 percent of all cancer deaths are men."

Notably absent from the basic cancer insurance presentation is any mention of the fact that cancer is the cause of only 1 out of every 6 deaths, and that many advances have been made in the treatment and cure for cancer. For example, in the early 1900's, few cancer patients had any hope of long-term survival. In the 1930's less than 1-in-5 were alive after treatment. In the 1950's, it was 1-in-4. Now the ratio is 1-in-3. However, it is estimated today that half of all cancer victims could be saved with earlier diagnosis and prompt treatment.

Quite obviously, alleviating or reducing a person's fear regarding a bout with cancer would certainly not be the method an agent selling cancer insurance would wish to embrace if he intends to sell his product. Arousing a prospective buyer's fear regarding cancer and its consequences is certainly one key to a successful cancer policy sale. And we know it does not take much to arouse a person's fear of cancer—a recent Gallop poll revealed that 58 percent of Americans fear being struck by cancer more than any other disease.

WHAT YOU GET IF YOU PURCHASE A CANCER CARE POLICY AND  
WHAT YOU DON'T GET"

After arousing one's fear of cancer and establishing the need for the cancer policy the only question an agent need ask after making the above-mentioned presentation is "Have you or any member of your immediate family ever been positively diagnosed by a doctor or pathologist as having cancer?" If the response is no, the prospect is informed that they and their family qualify for coverage under the cancer program which will become effective 60 days after the policy becomes effective. The prospect is also told that the policy is guaranteed renewable not just to age 65, but for life and that premiums do not increase or decrease because of age (although it does appear in small print in the brochures). What is not mentioned is that the premiums can increase if the commissioner of insurance approves an increase for all holders of a particular policy in force in a particular state.

Ms. Gardner was then told that the next step was to discuss benefits of the cancer program with the prospective client. The following is a discussion of the basic benefits of a typical cancer policy sold by this company in the State of Maryland, together with what a Washington, D.C./Maryland metropolitan area policyholder could expect to collect if stricken with cancer:

*Hospital confinement.*—A prospect is told that the company will pay them \$60 per day for the first 12 days they are confined in a hospital with cancer, and \$40 per day thereafter. The company's key selling point here is that there is no limit to the number of confinements, and if the prospect is out of the hospital for 30 days, the plan starts all over again and will pay \$60 for the first 12 days and \$40 a day for each day thereafter.

WHAT IS NOT MENTIONED is that the average stay in a hospital is only about 7 days and that the average cancer patient is only hospitalized 1.8 times in a 2 year period. A patient confined in a \$200-a-day room, for 12½ days ( $7 \times 1.8$ ) would run up a bill of \$2,520 in basic hospital charges. The company's cancer policy would pay \$740, or only about one-fourth of this bill. In addition, this benefit is paid only in a hospital.

*Convalescence.*—A prospect is told that the company will pay an additional \$15 a day as a convalescence fee for the first 12 days of hospitalization, \$15 added to the hospital confinement benefit brings the total benefit for the first 12 days up to \$75 a day.

WHAT IS NOT MENTIONED is that this would bring the company contribution for a 12½ day hospital stay up to only \$915—still paying only about one-third of the patient's hospital bill.

*Drugs and medicine.*—In addition to the benefits received above, the prospect is told that the company will pay 15% of their total hospital confinement benefit for drugs and medicine. An example the agent uses to clarify this benefit is: "In other words, if we paid you \$10,000 under hospital confinement, we would pay up to \$1,500 for drugs and medicines."

WHAT IS NOT MENTIONED is that in order to receive \$10,000 under the hospital confinement benefit, an individual would have to spend approximately 315 consecutive days in the hospital. Government statistics show that fewer than 10 percent of cancer patients stay in the hospital for as long as 35 days, so the percentage who stay 315 is obviously very few, if any. For an average 7-day hospital stay cancer insurance would pay \$420 under the hospital confinement benefit. Then cancer policy would pay 15 percent, or \$63, for drugs and medicines. In addition, remember that this benefit is paid only for drugs and medicines administered in the hospital.

*Surgical.*—A prospect is told that benefits will be provided for surgery in or out of the hospital. The company's key selling point here is that they will pay \$50 to \$750 per operation according to the schedule in the policy and there is no limit on the number of operations.

WHAT IS NOT MENTIONED is the discrepancy between their schedule of surgical benefits in relation to the actual cost of the operation. For example, the company's brochure warns that cancer is the leading cause of death for women between the ages of 30 and 54, primarily due to the incidence of breast cancer. In addition, they advertise that the incidence of lung cancer in men has increased 2,000 percent since 1930. Company according to a sample policy, will pay \$390 for a lobectomy (removal of a lung). However, the average cost for a lobectomy in the Washington, D.C. Metropolitan area ranges from \$500 to \$2,000! For a radical mastectomy—unilateral (removal of one breast), company will pay \$270. However, the average cost for a radical mastectomy—unilateral in the Washington, D.C. Metropolitan area ranges from \$500 to \$1,500.

*Physician.*—In addition to surgery, the prospect is informed that company will pay for your personal physician. They will pay \$10 a day or 90 one day visits. A limit of \$900 is placed on this benefit.

WHAT IS NOT MENTIONED is that the average physician in the Washington, D.C. Metropolitan area will charge a cancer patient anywhere from \$40 to \$170 for one in-hospital visit! At best, under the cancer policy the holder can expect to receive no more than one-fourth of their physician's bill to be paid by the company. Remember, this benefit is only provided for in-hospital physician visits.

*Private nursing.*—A prospect is told that the company will pay \$25 a day for either a R.N. or L.P.N. This benefit is paid only for nursing care in the hospital and the maximum benefits paid cannot exceed \$1,500.

WHAT IS NOT MENTIONED is that the average cost for a nurse in the Washington, D.C. Metropolitan area is \$65 for an 8 hour shift, or \$195 a day in the hospital. The company cancer policy will pay only one-eighth of the bill for nursing care. Cancer policy does not cover nursing outside the hospital at all—which averages \$30 for a 45 minute visit.

*Radiotherapy and chemotherapy.*—A prospect is told that the company will pay actual charges up to \$1,500 for X-ray, radium, cobalt or chemotherapy treatments.

WHAT IS NOT MENTIONED is that the cost for radiotherapy or chemotherapy treatment for a lobectomy, mentioned earlier under surgical benefits, in the Washington, D.C. Metropolitan area ranges from \$350 to \$500. For a radical mastectomy—unilateral, also mentioned under surgical benefits, the bill ranges from \$350 to \$500. Under the company can-

cer policy, an individual could exhaust his/her lifetime coverage of \$1,500 after three radiotherapy or chemotherapy treatments for either of these two cases of cancer!

*Anesthesia.*—The prospect is told that the company will pay for anesthesia administered in or out of the hospital according to the schedule in the individual's policy. The company's key selling point here is that like surgery benefits, there is no limit to the number of operations for anesthesia.

**WHAT IS NOT MENTIONED** is the discrepancy between their schedule of anesthesia benefits which bears little relation to the actual cost of administering anesthesia. For example, the company will pay \$165 for anesthesia administered during a lobectomy, mentioned earlier. However, the cost for administering anesthesia in the Washington, D.C. Metropolitan area for this same operation ranges from \$300 to \$350. For a radical mastectomy, the company pays \$45. The average cost in the Washington, D.C. Metropolitan area for administering anesthesia for this same operation ranges from \$200 to \$250!

*Blood and plasma.*—A prospect is told that this benefit is worth the entire cost of the program. The company cancer policy will pay actual expenses for blood plasma up to \$700, but there is no lifetime limit for Leukemia—and Leukemia is the leading cause of death for school age children. This benefit is paid by the company in or out of the hospital.

**WHAT IS NOT MENTIONED** is that frequently hospitals do not want money for blood, but rather they prefer to have the blood replaced by donors in the name of the patients, in which case there is no charge to the patient. If donors are required to replace the blood, this benefit is worthless.

*Ambulance.*—The prospect is told that the company will provide up to \$50 per hospital confinement for ambulance charges up to \$600 which would be like 12 trips to the hospital. The key selling point here is that few people will ever use up their limit of 12 trips to the hospital.

**WHAT IS NOT MENTIONED** is that unlike victims of emergency health conditions, i.e., heart attack victims, most cancer patients do not suffer from attacks of cancer and usually can get to a hospital without the assistance of an ambulance. This is not documented, rather a view shared by the committee staff. (In many cases, it should be noted, cancer patients may suffer from complications of cancer which will require ambulance service—however, in such cases, cancer policies may not reimburse the policyholder. For example, a cancer patient who suffers a heart attack or kidney failure as a complication of cancer—the company may not pay, arguing that its policy does not pay for heart attacks or kidney failure—it is a cancer-only policy).

*Government hospitalization.*—A prospect is told that if he or she is already eligible for Government hospitalization they

are fortunate. Because their expenses are already covered, the cancer policy will not pay the abovementioned benefits. However, the prospect will be paid \$40 a day for the first 30 days and \$30 a day thereafter. The key selling point to this benefit is there is no limit on the number of days. This benefit is to help out with the nonmedical expenses mentioned earlier in the initial presentation.

WHAT IS NOT MENTIONED here or in the initial presentation is that the nonmedical expenses for a late-discovered cancer in an industrial worker can cost a company upwards of \$42,000. The cost of a fatal cancer of the uterus, can amount to \$25,000 or more. Patients in these cases may have longer than average hospital stays, but if these cancer victims were hospitalized the average 12 day period, the company would pay some \$480, or 1.2 percent of the industrial worker's non-medical bill, and 2 percent of the female's nonmedical bill.

*Extended benefits.*—The prospect is told that most cancer patients must use private hospitals. One of the best benefits cancer policy offers is that after 3 months of continuous hospitalization, they will pay 100 percent of the actual hospital confinement and drugs and medicine charges up to \$6,000 per month. The key selling point here is that there are no lifetime dollar maximums nor time limits on this benefit.

WHAT IS NOT MENTIONED is that is it doubtful that a cancer victim will ever make use of this benefit. According to a 1978 *Consumer Reports* article, "government statistics show that fewer than 10 percent of cancer patients stay in the hospital for as long as 35 days, so the percentage who stay more than 90 days is obviously smaller still."

IF YOU CAN'T AFFORD \$5 A MONTH—YOU CAN'T AFFORD CANCER,  
CAN YOU?

During a training session held at the Maryland office of the company, an agent whose specialty was acknowledged to be high pressure tactics, explained to Ms. Gardner that after discussing the benefits of the cancer program, there are basically only five common objections that will be raised by the prospective customer. The responses to these five objections are critical, he said. They will either sell or lose the policy. The objections given and suggested responses include:

*Objection:* But I already have the best health insurance available.

*Response:* I am sure you do. Many have the finest insurance available, and I am sure you do, too. But even the finest insurance policy today pays the hospital. The cancer policy will pay you directly for not only medical expenses, but for non-medical expenses as well. Now, how do you spell your last name . . .

*Objection:* I would like to think this policy over.

*Response:* Do think it over. We don't know if cancer will strike us in 5 years from now. What we do know, however, is that only one family out of three in your neighborhood will not be affected by this disease. Now, how do you spell your last name . . .

*Objection:* I am already insurance poor. The last thing I need is another policy.

*Response:* I know how you feel. I have the same insurance problems. But the most important thing about insurance is the protection it offers against big bills. Cancer is a big bill—Leukemia is a catastrophic illness. For example, you have to have home insurance here in the State of Maryland. You will pay probably around \$200 a year for fire insurance and the chance of a fire is about 1 in 25. You will only pay \$50 a year for cancer insurance and your chances of getting cancer are 1 in 4. Now, how do you spell your last name . . .

*Objection:* Who is your company anyway?

*Response:* Our company is the 5th largest health care company in the nation; 60 percent of all cancer insurance is sold by our company. We sell to the best organizations, including (name few in area). Now, how do you spell your last name . . .

*Objection:* I haven't the money to buy this insurance.

*Response:* If you can't afford \$5 a month for this insurance, then you certainly can't afford cancer, can you? Now, how do you spell your last name . . .

#### WHO AND WHAT WILL NOT BE COVERED UNDER THE CANCER POLICY?

As mentioned earlier, the cancer policy cannot be sold to any person who has had cancer diagnosed prior to the effective date of the policy, or to anyone who has cancer diagnosed during the first 60 days after the effective date of the policy.

It is also important to remember that this policy is a cancer only policy and provides benefits only for loss resulting from definitive cancer treatment. Therefore, before collecting benefits under this policy, a policyholder must have positive pathologic proof of diagnosis. Cancer must be diagnosed by a pathologist, not the physician, whose report must be attached to any claim submitted for payment. Other diseases and accidents are not covered. Since some doctors diagnose late stages of cancer without pathology reports and because cancer, by its very nature, complicates other parts of the body, concern has been expressed about whether the policy will pay for such complications. This concern will be expanded upon later in this section.

In addition to being a cancer only policy, the cancer policy will not provide benefits to cancer victims while they are in nursing homes or extended care facilities, such as hospices. As mentioned earlier, benefits are also not provided to those policyholders in government hospitals, except for the daily rate.

But there are other costs associated with cancer which are not addressed by the cancer policy. According to the American Cancer Society these include: higher charges for out-patient services, home health services, private nursing services, drugs, pathology reports, sickroom equipment, transportation, and durable medical supplies—none of which the company's cancer policy mentions it will pay for. Remember that the company's key selling point for this policy is that they will reimburse the policyholder directly to assist them in paying the high costs associated with the nonmedical aspects of cancer:

[F]orty percent of the costs of cancer are non-medical  
 If you have to fly, your transportation costs are yours . . .  
 If there are children at home, child care may be yours . . .  
 When you return, you may need additional cash for private nursing. In the meantime, you may have suffered from the largest non-medical expense—loss of income . . . and your regular living expenses and bills have to be paid. The key to our cancer program . . . is to pay you directly so that you can meet the non-medical expenses of cancer like transportation and loss of income, etc . . .

Although one is led to believe that cancer is designed to cover the non-medical costs of cancer, all benefits in the cancer program are keyed to the medical aspects of cancer—which the company admits is already covered by the prospect's major medical plan:

The reason wasn't because major medical didn't do its job, it did! But they discovered that many if not most of the costs of cancer today may be non-medical—in other words, many of the costs of cancer have nothing to do with hospitalization at all.

Nevertheless, the cancer policy benefits are keyed to services rendered during a stay in a hospital—which the company, the American Cancer Society and the committee knows will not be long.

#### A CASE STUDY

Upon examination, the committee also discovered that victims of many common forms of cancer can expect to receive benefits under the policy so small as to be economically inconsequential. For example, the committee reviewed the case of Ms. X. She was one of over 40,000 women who were diagnosed with cervical carcinoma in situ in 1978. This form of cancer, when active, is the fourth highest cause of cancer death in women. Assuming that she purchased her policy in January of 1978, beginning 60 days after the effective date of her policy she was eligible for benefits under her cancer policy plan, she would receive the following benefits:

*Hospital confinement.*—None. She had an operation on an out-patient basis. She was in the hospital for 3 hours.

*Drugs and medicine.*—None. This benefit is based on a percentage of the hospital confinement benefit.

*Convalescence.*—None. This benefit is based on the hospital confinement benefit.

*Surgical.*—The committee staff estimates \$50. The policy reviewed by the committee does not include the benefit amount on its schedule of operations.

*Physician.*—None. Patient was not in the hospital for 1 day.

*Private nursing.*—None. Patient was not in the hospital for a day.

*Radiotherapy or chemotherapy.*—None. Radiotherapy/chemotherapy treatment were not administered.

*Anesthesia.*—\$30. This benefit is keyed to the surgical benefit. See above.

*Blood and plasma.*—None. No blood administered.

*Ambulance.*—None. Ambulance was not used.

*Government hospital confinement.*—None. Not confined in a government hospital.

*Extended benefit.*—None. The benefit is paid only after the cancer patient has been hospitalized for more than 90 days.

Ms. X's total medical and nonmedical related expenses associated with the cancer, including physician's visits, drugs and pathology reports exceeded \$2,000 since March of 1978. By January of 1979 her cost will have doubled. As is common with this disease, the operation will be repeated pushing the cost of treatment to about \$4,000. The question is how much would the policy pay? It is calculated that from the policy for which she paid a premium of \$100 (\$50 a year), she will receive something like \$160 in benefits. The company may suggest that the policyholder at least got her money back and then some but the fact is only the 1 out of 6 who actually contract cancer will break even or do better. It is obvious that the company, at least in this example, would not live up to its promise—"to assist in paying 40 percent of the costs of cancer which are nonmedical."

#### A WELL-PAID SALES FORCE

"You can make \$47,400 for the first year you are with the company. That beats your teaching job, doesn't it? More importantly, you can make that by working only 200 days a year. That will leave you 165 days to relax and take a long vacation."

That is how the conversation began when Ms. Gardner asked what a new agent could expect to earn with the Maryland office of the company specializing in cancer insurance. She was told that compensation of State, regional and district managers, and sales associates (agents) was based solely on commissions derived from initial sales and renewals. The trainee would receive no expense or office allowance.

Ms. Gardner was informed that her commission would be 50 percent of the premiums collected on each policy sold. In addition, the trainee would receive 10 percent of the policy

premium due and collected on each policy renewal after the initial mode's premium payment. According to the Maryland office state manager, if the trainee made 6 annual cancer policy sales to families a day she would receive a commission of \$225 per day. In 200 days, she would earn \$45,000 plus \$2,400 in stock totalling \$47,000. And a five-year projected income of \$282,000.

If, however, the trainee averaged only three sales a day, she could expect a salary of \$21,200 but in 6 years could still expect to receive \$157,200.

In addition to commissions, an agent can also expect to receive numerous awards, attend all expense paid vacations at conventions held in such places as Las Vegas, Mexico, Los Angeles, Washington, D.C., and participate in a variety of contests, if production meets certain standards. For example, Ms. Gardner was told that if she sold approximately \$26,000 in premiums in a 6-month period—she would be eligible for an upcoming trip to Los Angeles. Also, Maryland agents were told that if the State reached its goal of selling \$1 million of premiums in 1978 they would be treated to dinner at the finest restaurant in Glen Burnie, Maryland. The company believes that such rewards provide stimuli for increased sales production.

Very limited information was obtained about the company's complaint ratio. However, scattered experience shows the company has a better record than most companies specializing in medicare supplementary policies. For example, the company's 1977 complaint ratio was 0.45/\$100,000 in premiums in Arizona; 0.17/\$100,000 in Tennessee; 1.60/\$100,000 in Kansas and 0.49 complaints per each \$100,000 in Wisconsin—in Wisconsin this ratio is 233 percent of the States 0.21/\$100,000 average.

In summary, the staff concluded that (1) dread disease policies had very limited economic value; (2) some companies use scare tactics to induce people to buy their policy; and (3) a large number of elderly are being loaded up with cancer policies in addition to their overlapping and duplicative medicare supplementary policies.

The staff concluded that a more detailed study of dread disease policies was in order. The committee has asked the General Accounting Office to evaluate the economic value of several cancer policies and report back at the earliest possible opportunity. While these results need to be fully evaluated and we want to hear from other companies in the field, the staff is presently in agreement with *Consumer Reports* which criticized dread disease policies in its June 1978 edition saying:

Money spent on the purchase of a cancer insurance policy could be spent more effectively on improving one's comprehensive health insurance coverage.

NOVEMBER 28, 1978 HEARINGS OF THE HOUSE SELECT COMMITTEE ON  
AGING

At the November 28, 1978 hearings, Congressman Mario Biaggi, Chairman of the Subcommittee on Human Services of the Committee, revealed that he had agreed to document firsthand the sales practices used by agents selling cancer insurance. Biaggi posed as a retiree and listened to the sales pitches and scare tactics of several agents which were filmed and later shown on the air by ABC News. Two of the agents represented American Family Life Assurance Company.

The events led Biaggi to call New York Superintendent of Insurance, Al Lewis, as a witness before the Committee. Superintendent Lewis directed his remarks at cancer policies sold through the mails and noted that he could not stop such policies from being sold in New York despite a general ban on cancer insurance policies. Superintendent Lewis called for the Congress to act to fill a loophole in law which allows mail order policies to avoid regulation. (Details are carried in Section VII of this report.)

Amplifying his role to *Sales and Marketing Management*, Congressman Biaggi said:

They told me that one out of four people dies of cancer and they tried to create the impression that their policy provides all the additional monies you need if you get the disease. That isn't so.

JANUARY 1979 RESPONSE FROM AMERICAN FAMILY

American Family Life Assurance Company vehemently disputed the conclusions in the Committee's staff report. They asked permission to file a full response in the record of the Committee's November 28, 1978 hearing. Excerpts from that response follow:

American Family is a mature, well-established, and solid company. It enjoys an excellent reputation among its policyholders and claimants. It is presently rated A (Excellent) by Best's insurance rating service . . . Only 11.1 percent of our new insureds are over 65 years old. A number of these elderly policyholders are employed and pay their premiums through payroll deductions.

More significantly, the criticisms of American Family in the Staff Study represent a misconception of the nature of the Company's cancer insurance. The staff uses an unreasonably narrow concept of economic value, and its criticisms of sales techniques are based on misinformation.

As discussed below in this memorandum:

- (1) American Family's cancer policies provide very substantial coverage of the medical costs of cancer.
- (2) American Family's multiyear loss ratios are reasonable—which means that the policy premiums bear an appropriate relation to the value of the lifetime protection afforded by those policies.
- (3) American Family's sales practices are sound and responsible.

(4) American Family policyholders are pleased with their cancer insurance and would recommend it to others.

#### ECONOMIC VALUE

The Staff Study questions the economic value of American Family cancer insurance primarily because the policies do not cover *all* expenses of a cancer illness, and because American Family's "loss ratio" in the staff's view, is inadequate.

As indicated above, American Family's cancer insurance is supplemental to other health coverage, and its sales literature and presentations reflect this fact. American Family does not seek to cover the total expenses but rather to provide reimbursements of amounts which are not covered by other insurers. American Family's own studies indicate that its payments generally cover 35-40 percent of their policyholders' cancer medical expenses—based on an average hospital stay of 15.6 days, not the seven days assumed in the Staff Study. This obviously represents very significant supplemental coverage.

The Staff Study also evaluates American Family's policies based on "current loss ratio"—the amount of claims incurred in each year compared to the premiums earned for that year. This only reflects a statistic relative to an arbitrarily selected statutory accounting period. To a consumer covered by cancer insurance, this definition of loss ratio has little meaning. What the cancer insurance consumer needs to consider is the premium charged in relation to the benefits that may reasonably be anticipated during his or her lifetime.

Renewability of American Family's cancer policies is guaranteed. Those policies therefore provide lifetime protection for policyholders, without risk of cancellation or any age or health-related premium adjustments. The Company can only raise premiums on a uniform basis, and any such increases are subject to regulatory controls.

Accordingly, based on present actuarial calculations, American Family will have increasing claims experience as the policies and the individuals age. Attached is a chart (Exhibit B) that reflects this effect. It presents the loss ratio on a claims paid/earned premium basis for each issue year for all American Family policies. For example, policies issued five years ago (i.e., in 1973) had a loss ratio (sic) in 1977 of 52.2 percent; policies issued ten years ago (i.e., in 1968) had a loss ratio (sic) in 1977 of 78.1 percent.

In other exhibits filed with the Committee, E. Paul Barnhart, a consulting actuary for the company, calculated 30 year or lifetime loss ratios for the company. He says:

The National Association of Insurance Commissioners follows the guidelines that, for accident and sickness coverage of this type, a reasonable expected loss ratio is 50%. Since the above analysis shows that the expected loss ratio of American

Family Life cancer expense insurance, based on actual company experience, is 56.09% using 5% interest discount, and 64.74% using zero discount, it is clear, in my opinion, that the benefits provided are entirely reasonable in relation to the premiums charged, and policy holders receive a fair and reasonable benefit return on premiums paid, as measured by the guidelines recognized by the National Association of Insurance Commissioners . . . Of particular interest to this Committee is the worth of a cancer policy to the elderly. Principally because the policies have a uniform premium for all ages, they are especially valuable to the elderly, who have a higher incidence of cancer. This is shown by the Company's higher expected current loss ratios for those policies even in the first year after issue.

#### SALES TECHNIQUES

The Staff Study, based on limited and unreliable information, criticizes the techniques used in selling cancer insurance. Their evaluations of the sales practices of various companies are subjective to an unfortunate degree, and depend excessively on scattered, anecdotal information. The staff would have been better advised to rely on more companies and objective studies of these matters.

American Family takes strong exception to criticisms of its sales practices. The Company's sales force consists largely of experienced independent agents of proven integrity and skill. American Family policies are predominantly marketed through employers or associations and not on the basis of direct door-to-door solicitation. If American Family's marketing were indeed deficient, this would undoubtedly be reflected in the complaint statistics—yet even the Staff Study concedes that American Family's record is comparatively good, upon an analysis of state insurance commission statistics.

The attached analysis of inquiries from state insurance departments to American Family (Exhibit D) shows that only 297 inquiries were received by the Company during 1977. When compared to the total policies in force, this figure represents only one inquiry for each 11,518 policies in force. Of these inquiries, only 136 related to claims, and claims-related complaints are often an indication of improper sales presentation.

#### SUMMARY AND CONCLUSIONS

Throughout history, virtually every departure from conventionality has been met with suspicion. So is it with cancer insurance today. Cancer insurance exists because cancer is a disease of very high incidence, especially when considered on a family basis, and because treatment of the disease tends to be protracted and expensive. When 2.8 million Americans make an informed decision to purchase cancer insurance, and are generally well-satisfied with the product, then that insur-

ance has an indisputable value to them. In America, where consumers are still allowed to make most decisions for themselves, one must begin with the assumption that additional consumer choices are socially useful.

#### JANUARY 15, 1979, BUSINESS WEEK

Noting that heart disease kills far more people than cancer, *Business Week* notes that there is tremendous fear of cancer in American society. It continues:

Cashing in on this fear is the obscure but increasingly controversial American Family Life Assurance Company of Columbus, Ga., which 15 years ago became the nation's first marketer of insurance policies that cover the expenses of treating cancer. On the strength of that business, which accounts for 85 percent of its revenues, American Family ranks 69th among North American life, accident, and health insurance companies, as measured in premiums (or revenues), up from 372nd a decade ago. In just five years, American Family's premium income soared 294 percent, to \$205 million in 1977, while its earnings climbed 181 percent to \$25 million. Even though as many as 300 insurance companies—mostly smaller ones—offer similar coverage, 60 percent of all cancer policies in force have been written by American Family.

With the company's success in cancer insurance has come a measure of notoriety. Increasingly, critics both within the industry and outside the insurance fraternity, such as state regulators, consumer groups, and even representatives of the National Cancer Foundation, are damning cancer insurance. These opponents argue that it is little more than a mercenary exploitation of public fear, and that it is a bad buy, offering only paltry benefits for the cost.

Most of the country's big life insurance companies, which as a rule also offer accident and health programs, do not sell cancer policies. These insurers contend that people are better off under a more comprehensive health plan covering all other diseases and cancer. "If a person buys cancer insurance, he's only partially covered," says Alan N. Ferguson, vice-president and actuary for Prudential Insurance Co. of America. "It's like insuring only part of your house against fire."

Far harsher was the condemnation by one executive with a major insurance company, who declares: "American Family is selling garbage. And they're making a lot of money on it. Their appeal is to the fears of people—pure and simple."

Although Amos denies it, American Family is looking more and more like a company hedging its bets by seeking other markets and businesses now that its traditional line is under fire. The insurance company's corporate parent, American Family Corp., has branched out in the past year by purchasing four commercial TV stations in Georgia, Ala-

bama, and Missouri for about \$36 million. Within eight years the company plans to own five TV outlets and 14 radio stations, the legal maximum.

*Business Week* added:

Some state insurance watchdogs charge that another key to the success and profitability of the cancer marketers is that too little is paid out in benefits. "When you end up with multiple policies, you're usually paying what amounts to duplicate premiums for too little coverage," says Peter F. Kelly, director of financial and regulated affairs for the Connecticut Insurance Dept.

"I have never seen a specific disease policy with a high loss-ratio (benefits paid related to premiums collected)," says one state insurance commissioner. "I am deeply concerned about cancer insurance, because I believe it is sold by people improperly using high-pressure tactics without sufficient disclosure about the product."

For his part, Amos seems more angered than worried by the regulators' accusations. "They don't know what they're talking about," he snorts.

In fact, American Family's loss ratio does not reflect an overly generous payout policy. Most states want accident and health companies to dispense as benefits at least 50 percent of their premium income, and the industry average is 75 percent. American Family's payout ratio last year was 59.4 percent, and even that below-average level may be the result of a liberal estimate of future benefits to be paid on present claims. American Family's reserve for such future payments, which is counted on the benefit side of the equation, grew five-fold between 1974 and 1977, although premiums and paid benefits grew only threefold.

#### JUNE 1979, WASHINGTON POST

On June 11, 1979, the *Washington Post* carried an article under the byline of Ted Gupp, entitled, "Cancer Insurance Coming Under Increasing Attack."

The article is excerpted below:

Barely seven weeks after the nuclear accident at Three Mile Island power plant, Mutual of Omaha began an intensive sales campaign in the Harrisburg, Pa. area for what has become one of its hottest selling products: cancer insurance.

"You kind of hate to capitalize on something like that," says a Mutual sales manager in Harrisburg, who nonetheless confirms that his agents went door to door warning residents there that they may risk cancer because of radiation that leaked from the power plant.

The Mutual agents are not alone in their hard-sell tactics. In Charleston, S.C., residents recently opened personalized letters from a Pennsylvania insurance company telling them how many of their neighbors could expect to develop cancer.

"Mr. Smith, I don't have to remind you," a typical letter would say, "that Joan (Smith's daughter) or John (his son) may be one of these unfortunate people."

Thanks to blunt sales pitches like that and what some critics claim are miserly benefits, cancer insurance policies have become both an economic bonanza and a troublesome issue for the nation's insurance industry.

Although precise figures on the national sales of cancer insurance are not available, there is no doubt among industry officials that the fears of sky rocketing hospital costs and mounting evidence that cancer-causing agents are widespread in the nation's diet have created a sellers' market for the policies. Typically, cancer policies cost \$40 to \$150 a year and promise to meet many of the cancer treatment bills that can be beyond the coverage of other insurance plans.

But complaints about the policies are widespread. "It's one of the biggest frauds in the insurance industry," says Ralph Nader, the consumer advocate.

The Federal Trade Commission, in a recent policy paper, says buying cancer insurance, or any other policy specifically covering a "dread disease" is "more like buying a lottery ticket" than needed health protection. Even as a lottery the policies are "not a very good gamble," the FTC says.

Insurance firms offering the policies and some of their customers argue with that reasoning, saying they offer the promise of coping with the catastrophic costs of some cancer treatments. And, after all, says John Cooney, president of Union Fidelity Life Insurance Co., one of the major cancer insurance sellers, "everything has to be sold, no matter how meritorious the product is."

The states of New York, Connecticut, and New Jersey disagree and have banned outright the sales of cancer insurance and other "dread disease" policies.

**The *Post* continued:**

In Virginia, Maryland and the District of Columbia, however, cancer insurance continues to flourish virtually unfettered by regulation. American Family Life Assurance Co. of Columbus, Ga., the nation's largest cancer insurance firm, claims 200,000 policy holders in Virginia, 23,000 in Maryland and another 23,000 in the District. The number of other cancer policyholders in the area is unknown to insurance regulators.

Nationally, American Family Life alone claims eight million Americans now have its cancer policies and will account for most of its expected \$400 million income this year. In 1977, the company received \$170 million in premiums and paid out \$73 million in benefits, giving it what Robert Hunter, a Federal Insurance Administration official, calls an "outrageous" profit.

American Family Life President, John Amos, who created the company after reading the 1964 surgeon general's report

linking cigarette smoking to cancer, says his is simply a good business.

"It was like McDonald's went into hamburgers," he says, "I was looking for my own little niche and I found it."

Amos, a lawyer who 25 years ago was proclaiming, "God bless those who sue my clients," says his employees do not use "scare tactics." What his agents use are newspaper and broadcast accounts and American Cancer Society statistics about the perils of cancer.

The tactics of other salesmen can be more direct. "I'm selling it door to door," acknowledges a Mutual of Omaha agent in Harrisburg near the Three-Mile Island (TMI) plant. "People are very nervous, very anxious about TMI." In the first week that Mutual pushed cancer policies the agents easily sold about 100 policies there, the agent says.

One of the most blunt sales pitches has come from Union Fidelity Life Insurance Co. of Trevese, Pa. "If it takes you five minutes to read this brochure . . ." says one of their ads, "approximately six new cases of cancer were diagnosed" during that time.

The insurance fliers cite American Cancer Society figures, a point that troubles officials of the national charity. "They're using the fear of cancer to build one of the fastest growing businesses in the country," says Dr. William Markel, a Cancer Society executive. The Society urges the public to shun cancer insurance in favor of more comprehensive health insurance policies.

Most insurance executives say they disapprove of scare tactics, but some argue it's difficult to police an industry with so many sellers. "Agents have to eat every day," says Union Fidelity's Cooney. "Who knows what the agents are saying in the houses?"

*The Post* added:

Sales tactics aside, what troubles some cancer insurance critics is their payout of benefits. Large insurance firms typically return about 85 cents out of every dollar to their policyholders, according to the 1978 edition of the National Underwriters Argus, an industry publication. But American Family Life returned only half that amount—43 cents in 1977—the publication said. Some cancer insurance firms paid out 40 percent of their premiums or less, industry officials say.

Amos, of American Family, says the people who collect on his policies are many, and points to Mary Judd, a 71-year-old Washington widow, as typical.

"I think it's wonderful," said Judd, who collected \$3,000 after her husband died of prostate cancer in 1977. "My husband always said if we don't need it we're lucky and if we do need it we're lucky," she said. "That's the way I still feel."

In the parlance of insurance regulators, Judd was a "winner" someone that cancer insurance critics say is too infrequent in the industry.

An FTC policy paper criticized "dread disease" policies for their "fine print exclusions and unfair denials of claims."

Those who do collect often find the policy covers only a fraction of the costs of cancer treatment, which the American Cancer Society estimates averages about \$20,000 "from time of diagnosis to cure or death."

Consider the case of Mildred F. Perrie, a 70-year old widow living at 4204 Meade St., NE in the District. Her husband, Earl, a retired truck driver, died in September in Howard University Hospital of "bronchogenic carcinoma." A huge malignant growth had erupted through his chest wall, her lawyer says.

Perrie, who had taken out a cancer policy with Mutual Protective Insurance Company of Omaha, Neb., filed a claim with the company expecting to be paid approximately \$100 a day for hospitalization, plus portions of her husband's surgery and home-confinement costs.

Instead the company refused to pay, invoking a provision of the policy that required a pathologist's confirmation of cancer, according to her attorney, Marc Botzin. Clinical observation—what the examining physician observes from symptoms and experience, rather than actual cell samples did not suffice, Botzin said.

Perrie had been pathologically diagnosed for cancer on his final three visits to the hospital, the lawyer said. The company, after initially refusing to pay anything, offered to pay for the costs of the third treatment, Botzin said.

After an initial offer of \$2,000, Botzin told the company their policy was so restrictive as to be "unconscionable and unenforceable." He threatened to take the issue to court. The company quadrupled its offer and settled the claim, the lawyer said.

"I think the policy's a rip-off and they should be exposed for it," said Botzin.

Richard Norris, director of claims for Mutual Protective, said his company ultimately would have waived the provision requiring pathological confirmation of Perrie's condition. But he strongly defends the provision, calling it "a safeguard for the company," against false or unwarranted claims.

Perrie's problems, according to Dr. Alan Mondzac, chairman of the District Medical Society's cancer section, are not unique. "It's a loophole in the policy and it's not rare," he said. "The insurance company is just trying to find a way out. It's just not cricket."

**JUNE 13, 1979 HEARING BY THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT, HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE**

Congressman Claude Pepper, Chairman of the House Select Committee on Aging, testified before the Health Subcommittee on June 13, 1979. The Subcommittee met to consider Chairman Pepper's bill, The Senior Citizens Health Insurance Reform Act of 1979.

At that hearing, a colloquy took place between Chairman Pepper and Congressman Andrew Maguire. Congressman Maguire said:

I have one other question which is about cancer policies. I notice that you have gone into that in the staff study, particularly with some work in the State of Maryland, and I note that New Jersey is one of three States that has legislated against cancer policies or other dread disease policies, which really are another way of victimizing people and preying on their fears and their suffering, because these policies, like the ones you described for medigap coverage, simply do not do the job. People pay enormous amounts of money for almost no coverage that would ever be available to them, or if they got cancer, that would give them any coverage that was worth talking about. . . . I am just wondering if we need to do something additional. What does the bill do now about the dread disease policies, the cancer policies, which are now being sold, I understand, to people in the Harrisburg area after the nuclear accident there, door to door? They are selling these people policies which they think will somehow protect them against cancer or pay for cancer if they get it. Of course, neither of these things is true.

Chairman Pepper answered:

We are in a dilemma—those of us who want to protect these people are in a dilemma. Heretofore, Congress has enacted legislation against Federal Government regulation of insurance company operations on the theory that it is a matter that ought to be handled by the State. Now we find a flagrant lack of action of the proper character by the State, so we are looking around. What do we do? Do we reverse our previous abnegation of authority that we could assert, of the Federal Government regulating insurance, having to grant licenses, revoke licenses, police the operations of these companies and all that?

Or do we just do sort of the best we can to try to exert a wholesome Federal influence?

This bill is a very minor step in the right direction; at least it offers a hope that there will be some persuasive leadership given by the Federal Government to the States.

Your distinguished committee, if it were to approve this legislation, I am sure would have language in a report that would encourage the State to take the prime responsibility for that matter. This is a mild and a very timid beginning, but it is a beginning, and it does tend to protect people.

Take these cancer policies, I can't believe that the Department of HEW would approve these cancer policies that we have had presented to our committee. We intend, of course, that cancer policies be included in our bill.

Why, at our hearing, somebody got a big laugh in the hearing room when they read one of these 100-word sentences. A Philadelphia lawyer could hardly tell what it meant.

So, the HEW would say right away, "That is deceptive; it is not a meritorious policy. We don't approve that." Then the word would get around. We hope that X company, so-and-so company is selling these cancer policies that are not approved by HEW. I would hope that HEW through the Department of Aging, or the Commissioner of Aging, would try to disseminate information that this bill was on the statute books, if we enact it. All of them won't ever hear about it; all of them won't ever take advantage of it; but it would be a little step in the direction of Federal leadership.

At this same hearing, Washington, D.C. Attorney Marc H. Botzin submitted a statement concerning one of his clients who had a cancer insurance policy from the Mutual Protective Insurance Company. His statement reads as follows:

Shortly following the death of Earl Perrie on September 18, 1978, at age 71, this office was consulted by the widow of the deceased in connection with recovering benefits under a cancer insurance policy. This policy, a copy of which is attached, provides for daily benefits for hospital and home confinement due to cancer, as well as additional benefits for certain medications and surgical procedures.

Mr. Perrie died of respiratory failure due to a bronchogenic carcinoma which had grown through his chest. According to the death certificate, the cancer had been present for approximately eight months.

Mr. Perrie had been hospitalized on three occasions during 1978 for the treatment of cancer. He spent approximately 73 days in the hospital with intervening periods of home confinement. During each hospital admission, biopsies and tissue samples were taken to confirm the clinical diagnosis of cancer. According to the numerous pathology reports, the tissue samples were suggestive of malignancy but not conclusive. It was not until Mr. Perrie's third admission that a conclusive diagnosis of malignancy was made by a pathologist in conformance with Part 2 of the insurance policy.

After assembling documentation for his claim, the insurance company offered a settlement which appeared to pay benefits relating only to the third period of hospital confinement. The policy language prevented recovery for confinement related to the earlier two hospital admissions due to the failure to positively diagnose malignancy by laboratory methods. However, as the decedent was treated for a cancer condition which eventually killed him, and had been present prior to his first hospital admission, we question the purpose of the policy provision and the carrier's motive in invoking it. After consulting with the treating physician and the diagnosing pathologist, we are convinced that the requirement for a laboratory diagnosis of malignancy in a great number of cases is medically unreasonable. In fact, the treating physician was amazed that the insurance company would question his diagnosis after reviewing the patient's chart.

We were engaged in settlement negotiations with the insurance carrier from December, 1978, through May, 1979, at which time the claim for benefits was settled. The insurance company had been in possession of the relevant hospital records since the fall of 1978, and had consulted with a pathologist at Creighton University in an effort to document their denial of this claim. We point out these facts due to a statement contained in an article in the Washington Post on June 11, 1979. This article states that the director of claims for Mutual Protective Insurance Company, with whom we negotiated the settlement of his claim, said "this company ultimately would have waived the provision requiring pathology confirmation of Perrie's condition." We cannot imagine when the company intended to make such a waiver, as they never did.

Chairman Pepper also submitted several items for the record, including a December 22, 1978 news story about cancer insurance carried in Knight-Ridder newspapers. The story quotes former Pennsylvania Commissioner Herbert S. Denenberg as saying, "The only thing that's good about it (cancer insurance) is that it makes a lot of money for those selling it."

The Chairman also submitted various letters from senior citizens and experts on insurance as indicative of the kind of mail the House Aging Committee has received.

For example, an Illinois man wrote:

My mother is a 72-year old terminal cancer patient. For many years, she carried cancer insurance with an ITT unit located in Thorp, Wisconsin.

The insurance company paid benefits when she underwent a mastectomy some four years ago and then paid benefits again when a related tumor was removed a couple of years later.

Some eleven months ago, she suffered a pathological fracture of the femur caused by metastatic cancer as per the pathological report and correspondence to the insurance company from the attending physician-surgeon. The insurance company refused to pay any benefits even though benefits for such an occurrence are spelled out in the policy.

The elderly patient with a continuing cancer problem, and that is what cancer is—a continuing problem, certainly does not benefit from cancer insurance.

An Alabama man wrote:

We enclosed a copy of notification filed with your office by American Life Assurance Company of Columbus, Georgia for a enormous amount of premium increase on our cancer policies.

These policies carry a limited, stipulated, nailed down coverage, the same as has been through-out their existence, while there is no increase in its coverage or benefits whatsoever. This is **OVER A 50% INCREASE**.

American Family Life states that this increase is due to labor, postage, utilities and etc. No mention is made as to their

loss ratio. They do not even reach the National Association of Insurance Commissions suggested minimum loss ratio of 40% to 65%. It would be impossible with the limited stipulated coverage contained in these policies. . . .

These policy holders are those living on a fixed income, a majority of them, Senior Citizens who have carried these policies for years and cannot afford this increase. It would be tragic for them to be without this CANCER coverage when the need is at its greatest. Some of the premiums paid on these policies are being paid under protest.

A woman from Phoenix City, Alabama wrote in January 1979:

I am sending you everything that you need I think to show that American Family Life does not live up to its promises. I bought a cancer policy on October 15, 1971. It was for my husband and myself. I paid \$60 a year for it until this year when it went up to \$76.20. I was told by their agent, a Mr. ———, that as soon as I was found to have cancer, the company would pay all my bills and I wouldn't have to worry about paying for anything . . . H(e) painted a bleak future for me if I had cancer without the policy. I fell for it and even talked my mother into taking it too. I had a hard time getting anything out of them. In fact, I had to turn it over to my son-in-law who is a professor at Tallahassee, Florida University. I am still paying \$100 a month on the bill. The operation was on March 3, 1976.

In March 1979, an Iowa man wrote that his mother had been misled by an agent selling cancer insurance for Mutual Protective Insurance Company. At the time of purchase in July 1978, the insured informed the agent that she had had a malignant mole removed. The agent "specifically stated that it did not affect her eligibility." On March 13, 1979 the company denied claims submitted by the woman on the grounds of previously diagnosed cancer. "I submit the policy was sold by false assurances and suggest you reconsider your decision to pay benefits contracted for," he wrote to the company.

Insurance expert Donald B. Elliot, C.L.U. shared a copy of his letter to the Indiana Insurance Commissioner urging regulation of cancer insurance and the agents who sell it:

"Cancer and other dread disease" policies are designed to line the pockets of insurance company stockholders. The companies do not return a fair percentage of premium dollars to the policyholder in the form of benefits. Financial security does not come from contracts that pay "in-hospital" benefits only.

Companies that prey on our elderly citizens need regulation! If it isn't done by our insurance department, perhaps the Federal government will do it for us.

A man from Columbus, Georgia wrote:

Sir, I would like for you to investigate the recent tremendous rate hike of the American Family Life of a policy covering cancer. This policy has been issued for many years and now suddenly they have doubled the premiums blaming it on

inflation! This of course was done shortly after it was announced by the Board of Directors that they were giving Mr. John Amos a raise in salary to One Million Dollars per year! Mr. Amos I might add is the Chairman of the Board. Not only has the Company given him the pay raise but they have begun to systematically purchase both television and radio stations throughout the Southeast. Senator, the policy in question covers many of the now elderly citizens and in effect will force many to drop their insurance before ever recovering a dime in or from the effects of a cancer. As I view the premium raise, it is a form of blackmail, either upgrade your insurance to a larger cost or drop it! I have written, called and done all that I know to do to have the Insurance Commissioner of Georgia for an explanation of why he allowed the raise to go into effect but to date have heard nothing after several months.

Joseph M. Belth, Professor of Insurance at Indiana University's Graduate School of Business wrote to Chairman Pepper:

In my opinion, limited forms of insurance—whether life insurance or health insurance—generally constitute an irrational purchase. In the case of life insurance, why should a breadwinner's family be better protected if he dies in a plane crash than if he dies in an automobile accident on the way to the airport? Or, why should his family be better protected if he dies in an accident than if he dies of a heart attack? If a breadwinner has inadequate life insurance to meet his financial objectives for his family, he should buy more life insurance that will pay off regardless of how he happens to die. Similarly, in the case of medical expense insurance, why should a person be better protected against cancer than against the wide range of other illnesses and accidents that can produce enormous medical expenses? If a person does not have adequate medical expense insurance, he should buy more medical expense insurance that will pay off regardless of the type of illness or accident that generates the expense.

Not only are limited forms of insurance generally purchased irrationally, but also the marketing of such insurance places heavy emphasis on fear. The sale of all insurance is to some extent based on fear, but limited forms of insurance place particular emphasis on fear. For example, cancer insurance advertisements may feature—in large letters surrounded by a black border—the statement that “what happened to Nat King Cole could happen to you!” And just as the “white knuckle” type of airplane passenger is about to board the plane, there is the trip insurance counter or vending machine ready to make the impulse sale based heavily on fear . . .

While I view cancer insurance as a sales gimmick that encourages, perpetuates, and capitalizes upon the irrational behavior of many insurance buyers, I am reluctant to suggest that such insurance be banned. My reluctance stems from my unwillingness to restrict the freedom of people to make irrational purchases.

JUNE 1979 REPORT BY THE U.S. GENERAL ACCOUNTING OFFICE TO THE  
HOUSE SELECT COMMITTEE ON AGING

On June 13, 1979, Chairman Pepper released a report by the U.S. General Accounting Office which was asked to analyze the economic value of various dread disease and other Medicare supplementary health insurance policies. Part of the reason for Chairman Pepper's request to GAO was due to confusion about accurate loss ratio figures for various companies selling cancer insurance. Following are highlights from GAO's report:

- Loss ratio is the proportion of gross premiums which, on the average, is returned to policyholders in the form of benefits. As such it is an indicator of economic value of a policy form or forms offered for sale by an insurance company. Loss ratios are usually expressed in percentages. For example, if the loss ratio for a year (or other specified period) were 55 percent, this would mean that total benefits paid to policyholders—for illnesses originating during the period—would amount to 55 percent of the premiums which they had paid.

Moreover, although the loss ratio is used as a measure of economic value, it does not reflect other factors which should be considered in determining economic value such as:

- What other insurance is available covering the same illness or other contingency?
- Is the individual's financial situation such that he/she can reasonably afford to buy the insurance?
- If an individual has other insurance covering the same contingency will benefits payable on the new or an existing policy be reduced accordingly under a provision for "coordination of benefit?"
- GAO noted that the National Association of Insurance Commissioners suggested an accepted loss ratio guideline of 40–65 percent for health insurance policies issued to individuals and a minimum of 60 percent for policies sold in supplementation of Medicare.
- GAO determined that the following were accurate "aggregate actual loss ratios" for cancer insurance policies issued by the companies named below:

TABLE V

	Number of policy forms identified	Premiums earned (millions)	Losses incurred (millions)	Loss ratio (percent)
Union Fidelity Life Insurance Co., Trevese, Pa.—1976...	9	14.8	0.9	119
Liberty National Life Insurance Co., Birmingham, Ala.— 1977.....	14	21.3	5.5	26
American Family Life Assurance Co., Columbus, Ga.— 1977.....	28	152.6	64.9	43
Colonial Life and Accident Insurance Co., Columbia, S.C.—1977.....	5	5.2	2.5	49
Lone Star Life Insurance Co., Dallas, Tex.—1977.....	3	9.9	5.5	55

<sup>1</sup> 1 policy form accounted for \$4,500,000 or 94 percent of the \$4,800,000 in total premiums earned on the 9 policy forms. This policy form reported \$3,200,000 in premiums earned for the 1st year with a loss ratio of 13 percent, and \$1,300,000 in premiums earned for renewals during 1976 with a loss ratio of 37 percent.

<sup>2</sup> This number does not include policies no longer issued which the company grouped together for reporting purposes. Of the total premiums earned, \$1,600,000 is applicable to these policies.

GAO was also furnished with a copy of American Family's January 1979 response to the November 1978 report of the House Select Committee on Aging. That material indicated that by recomputing loss ratios to give recognition to (1) the disproportionate impact of new policies in recent years, and (2) the higher incidence of cancer for older persons, the expected lifetime loss ratios (30 years) for policies in force ranged from about 55 percent to 65 percent. GAO found three basic problems with American Family's report:

First, the study deviates from the prescribed format in the Accident and Health Policy Experience Exhibit for computing loss ratios and therefore unless other insurers go through the same exercise, comparisons among companies could not be made.

Second, the study's calculations assume that the policies are noncancellable—that is as long as an individual pays a stated premium amount the insurance will remain in force. In fact, the policies we looked at were guaranteed renewable, but the annual premiums can be increased as long as they are increased for everybody in a given class or jurisdiction. In this regard, we are aware that in 1978 the company did request and receive a premium increase for a cancer policy for policyholders in the District of Columbia. Therefore, we believe that the study's assumption that the premiums will remain the same over the expected 30-year lifetime of a policy is questionable.

Third, the study does not relate to any particular policy form sold by American Family (such as we were asked to look at), but appears to project the expected loss ratio on a hypothetical set of benefits.

It might be worth noting that Lindalee Lawrence and James J. Klopfer of the Massachusetts Insurance Department analyzed these same figures and made these comments in their May 24, 1979, testimony before the State legislature:

Consulting actuary, E. Paul Barnhart, using American Family's data regarding past performance of policies and acting in the company's behalf, has calculated an anticipated loss ratio of 56.09% for the company's cancer policies. Over a 30-year period, according to his estimate, American Family's cancer plans will pay benefits of 56 cents for each dollar of premiums that the company collects.

This loss ratio estimate does not tell the whole story about long-term policy performance, however, because it ignores investment income. Cancer insurers build up large active life reserves during the early years of a policy and then gradually return them to claimants in subsequent years. Since the interest earned on the reserves is really interest earned on the policyholder's premium dollars, the interest should be added to premiums in loss ratio calculations in order to present a true benefit-to-premium ratio.

We have calculated such a loss ratio for American Family, using the data underlying the 56% estimate and the reasonable assumption that the company can earn 6% on its investments. The adjusted loss ratio is 49%.

Although comparably detailed long-term loss ratio data are not available for the other three cancer insurers examined by the Division of Insurance, there is no reason to believe the overall performance of their cancer policies is better than that of American Family and some reason to doubt that it is as good.

Returning benefits of only 49 cents per premium dollar to all consumers over 30 years of a policy's lifetime, cancer insurance clearly is no bargain.

#### JUNE 17, 1979, THE PHILADELPHIA BULLETIN

The *Bulletin* ran a story by Stephen Franklin which described new State regulations which took effect on July 24 requiring insurance firms to provide minimum coverage benefits. The effect of these regulations is to strongly discourage the marketing of cancer insurance. The report begins:

The report begins:

**It's a sales pitch fed by fear and uncertainty.**

"If cancer strikes, where will you get the money you'll need for hospitalization . . . radium, cobalt, chemotherapy (drug treatment) or X-ray therapy" asked an advertisement placed in 12 Pennsylvania newspapers last week by a King of Prussia insurance firm.

"Don't be one of those who refuse to face the frightening facts of cancer," warned the ad from World Life and Health Insurance Co.

The article continues:

**On the surface, cancer insurance has appeal.**

It is cheap, generally costing between \$50 and \$150 a year. It is usually easy to get, and most companies selling it promise to pay the steep medical bills associated with cancer treatment.

But not everyone considers it a bargain. Its critics, including some state and federal officials, have wondered if it is any better protection against the high costs of cancer than an umbrella against a hurricane.

They say the policies, often sold through fear or high pressure sales tactics, are close to worthless because of too many limitations and restrictions that leave hospital and doctor bills unpaid.

The story quotes Robert Reich of the Federal Trade Commission as saying:

The coverage is not good at all. And the companies are making a large amount of money. Cancer insurance is really an embarrassment to the industry.

JUNE 1979, INVESTIGATION BY THE NATIONAL CREDIT UNION  
ADMINISTRATION

In June of 1979, the National Credit Union Administration, the federal agency established by Congress to oversee the operations of credit unions, began an investigation of cancer insurance given evidence that many credit unions were sharing their mailing lists with cancer insurers. It appears that the credit union would receive a percentage of premiums paid on each policy as their share for this cooperation. Often the fee is billed not as a commission but as administrative expense—a convenience perhaps to avoid violation of State laws which say that commissions cannot be shared with unlicensed individuals.

On June 24, 1979, Lawrence Connell, Chairman of the Administration, made a tough speech before the Credit Union Executive Society. He said in part :

Among new areas of concern at NCUA is the sale of cancer insurance and other group buying plans . . . It would be the most egregious affront to credit union principles to endorse or to recommend a service to members that preyed upon their deepest fears. At NCUA we will be studying sales of cancer insurance and other products which are endorsed by leagues. We have heard rumors that attractive commissions have been a common sales technique. Federal credit unions are prohibited from receiving reimbursement in excess of their administrative costs. We will enforce that regulation so there will be no direct threat to the integrity of their operations. However, we do have a concern about indirect compromise.

[W]e will conduct a study of insurance services sold to members through their credit unions.

NCUA's interest in the problem was heightened by a December 31, 1978 market conduct examination of the Loyal American Insurance Company undertaken by the Alabama Department of Insurance. Their report, on page 19, states the following :

The various credit unions finance and collect the premiums for the company from its members if they so desire. The company pays the credit union a service fee plus defraying certain expenses incurred by the credit unions. The individual ordinary life coverage is solicited on the members by the ordinary division agents of the company using the credit unions endorsement and the financing and collecting of premiums arrangement obtained by the group division.

The company utilizes its beach houses and condominiums in Alabama and Florida as a tool for the procurement of business by providing entertainment and/or vacation facilities for the managers and members of the board of directors of the credit unions and State credit union leagues. The two airplanes of the company are used in transporting the credit union officials to and from the beach facilities.

At page 57, the Alabama report provides a list of the property owned by the company and allegedly used for the purposes described. The list of property includes:

Description	Book value	Encumbrances	Admitted value
Frame house: 308 Pine Hill Dr., Mobile, Ala.....	\$27,536	0	\$27,536
Frame house: Dauphin Island, Ala.....	6,099	0	6,099
Frame house: Gulf Shores, Ala.....	32,740	\$10,425	22,315
Frame house: 304 Pine Hill Dr., Mobile, Ala.....	27,000	0	27,000
Frame house: 306 Pine Hill Dr., Mobile, Ala.....	25,174	0	25,174
Seacliff condominium: Daphne, Ala.....	33,738	0	33,738
Real estate: Long Beach, N.C.....	496,935	0	496,935
Frame house: Gulf Beach, Fla.....	78,308	0	78,308
Real estate: Escambia County, Fla.....	86,495	0	86,495
<b>Total.....</b>	<b>814,025</b>	<b>10,425</b>	<b>803,600</b>

The report describes each of these properties and provides more details as to their use. Following are examples (emphasis in original):

#### DAUPHIN ISLAND PROPERTY

This parcel located at Dauphin Island, Ala., was acquired in 1962 at a cost of \$18,000, and has a book and admitted value at December 31, 1978 of \$6,099. This property consists of a waterfront lot and a one-story frame cabin. The property is being depreciated over a period of 12 years.

This property is used primarily for the entertainment of clients of the company. *The use of this beach house is extended to the managers and members of the board of directors of medium size and small credit unions. Their stay is usually limited to one week.*

#### GULF SHORES PROPERTY

This parcel located at Gulf Shores, Ala., was acquired in 1969 at a cost of \$28,000. This property consists of a waterfront lot and a two-story frame cottage. The building was remodeled in 1972 and at December 31, 1978 had a book value of \$32,740 with an encumbrance of \$10,425, leaving a net book and admitted value of \$22,315. This property is being depreciated over a 30 year period. *The primary use of this beach house is extended to the managers and members of the board of directors of large credit unions and to the managing directors of the State credit leagues. Their stay is limited to one week.*

#### LAKE FOREST OR SEA CLIFF CONDOMINIUM

This condominium was purchased in July 1975 from Diamondhead Corp., an affiliate, in the name of an officer of the company, at a cost of \$36,489 with an encumbrance of \$30,516. This property was deeded to the company in February by the company officer. During this period the company showed this as real estate owned without legal title to the property. At December 31, 1978 the company had full and legal title to the

property which has a book and admitted value of \$33,738. This property is being depreciated over a 30 year period.

This condominium was purchased primarily for investment and has been used the last several years primarily for the housing of new employees until their re-location in Mobile has been completed. This prevents the company from paying motel or short-term apartment rent. Prior to this time it was used to house various agents or customers that were coming to Mobile for a short stay.<sup>1</sup>

JUNE 1979, INVESTIGATION BY THE SENATE COMMITTEE ON  
BANKING, HOUSING AND URBAN AFFAIRS

About this same time, the Senate Banking Committee opened an investigation of cancer insurance in the face of significant evidence that not only credit unions but also major oil companies and banks, through their credit cards, have been offering cancer insurance.

The investigation is pending.

AUGUST 28, 1979, THE WALL STREET JOURNAL

The *Journal* also quoted Robert Reich, Director of the Office of Policy Planning and Evaluation of the Federal Trade Commission, who said:

There is evidence that many companies selling cancer insurance are preying on the customer's fear of cancer through the use of scare tactics.

The *Journal* noted criticism from established health insurers:

Buying a cancer policy alone, instead of a comprehensive insurance plan is like "insuring a ship against fire but not against sinking," says Thomas A. Harnett, senior vice president and counsel of Travelers Insurance Company of Hartford, Connecticut.

The story continues:

Some of the concerns offering cancer insurance have used grim sales pitches to attract customers. "There are four in your family," warned a personalized letter sent by Union Fidelity Insurance Co. "Chances are that one of them will contract cancer." Another Union Fidelity brochure listed celebrities such as Babe Ruth and Jack Benny, both of whom had cancer, and stated, "This can happen to you."

Such ads can backfire, though. World Life & Health Insurance Co. recently withdrew an ad that said, "Don't be one of those people who refuses to face the frightening facts of cancer" after it ran a single time. Among the dozen cities where the ad ran was Harrisburg, Pa., near the Three-Mile Island nuclear reactor accident. "We dropped the ad because there was so much adverse criticism," says a World Life official. . . .

---

<sup>1</sup> See Appendix VI for examples of the company's advertising literature. As a result of these and other disclosures, on February 1, 1980 leaders of 30 State credit union leagues voluntarily took steps to create a model set of procedures and criteria to guide their endorsement of products or services offered to credit unions.

When an insurance salesman arrived at Morehouse College to hawk policies to faculty and staff members a few months ago, one of those who turned him down was Marcellus C. Barksdale, a history professor at the Atlanta school.

"I saw through the agent's hard-sell tactics," Mr. Barksdale says. "Though they didn't frighten me, I'm sure they did scare others and that is probably why they bought the insurance."

The *Journal* noted that:

Cancer insurers deny charges that they're overzealous in marketing their products. "Our sales force has strict orders to avoid using scare tactics," says Lee M. Parker, vice president, investor relations, for American Family Life. Adds Thomas Finnegan, a Union Fidelity Life vice president: "The public wants it or they wouldn't buy it."

#### SEPTEMBER 1979, STUDY BY THE STATE OF MASSACHUSETTS

On September 18, 1979, the Massachusetts Department of Insurance banned the sale of cancer insurance and referred several cancer insurers to the Attorney General for possible legal action.

The Massachusetts study—which is the most in-depth investigation of cancer insurance ever undertaken by any State is summarized in Section V of this report.

In banning cancer insurance, the Department decided that this coverage is often uneconomical, duplicative of existing health insurance, and sold on misleading terms.

The practical effect of the regulation is that any company which wishes to sell dread disease insurance must cover a broad range of such diseases—such as heart disease, various kinds of paralysis, chronic lung disease and severe burns or fractures—and not simply cancer.

Such broad based dread disease and accident insurance cannot be cancelled before an individual reaches age 65 and may be marketed only to individuals less than that age to prevent salesmen from preying upon the fears of the elderly who are considered adequately protected by a combination of Medicare and Medicare supplementary insurance.

#### DECEMBER 1979, CHANGING TIMES

In its December 1979 issue, *Changing Times* carried a story entitled, "Why Cancer Insurance is a Bad Buy." The story begins:

The sales letters pull no punches. "Cancer is so horrible and dreaded a disease that the normal reaction is to say, 'It can't happen to me.'" Yet the "odds are very high that someone in your family will be stricken . . . so you must protect yourself and your family from the crushing costs. . . . Most people's financial resources are no match for the overwhelming costs of today's treatment."

The message of Union Fidelity Life Insurance Co. of Trevese, Pa., continues: "For \$9.50 a month you and your entire family will be provided with up to \$200,000 per person to fight the smothering costs of cancer."

In part because of such scare tactics, the selling of cancer insurance, which pays off for that disease only, has become one of the fastest-growing businesses in America—even though few major insurers offer it and an impressive array of critics advise against buying it. They charge that insurers are exploiting fear and ignorance to market policies of dubious value.

The case against cancer insurance is persuasive.

Why the big push for cancer insurance when heart disease is the number one killer? The answer seems to be that public concern about the disease, heightened by frequent reports of cancer-causing substances in food and the environment, makes the policies easy to sell. "We're living in a cancer-anxious society," says a representative of the American Cancer Society. "The fear of cancer is oversold." Shortly after the nuclear power plant accident at Three-Mile Island in Pennsylvania, an agent for Mutual of Omaha was peddling cancer policies door-to-door in nearby Harrisburg (he sold 19 in all, the company says).

*Changing Times* notes that "it is almost universally agreed that people can get far more protection per premium dollar by increasing their comprehensive health and major medical insurance that pays for all diseases than by insuring themselves against specified diseases."

It continues:

It makes no more sense to take out a cancer policy than it does to take out a leprosy policy or a chicken pox policy, says Herbert S. Denenberg, an outspoken public-interest advocate and former Pennsylvania insurance commissioner (he banned cancer insurance there but was overruled by a court). Sam Allalouf, public relations director for Cancer Care and the National Cancer Foundation, which provide aid and guidance to people with advanced cancer and to their families, likens it to buying auto insurance policies part by part, with separate policies for the engine, radiator, transmission and other components.

The report adds:

Cancer insurers are fond of quoting glowing testimonials. "Had it not been for this Supplemental Plan we would have lost the business, our home, and everything else we owned," says Beryle M. Tomlinson of Brush, Colorado, whose husband spent ten and a half months in a hospital. But it's possible that had Tomlinson spent the same money on comprehensive health insurance, he might have received more in benefits.

*Changing Times* notes that some cancer insurers make much of the fact that their policies will provide a windfall—double recovery if a policyholder has comprehensive coverage. Continues the report:

But it's not always possible to collect from two or more insurance policies for the same health-care costs. True, a number of cancer policies promise to pay the beneficiary directly,

in cash, no matter how much he may receive from other insurance. However, the other insurance often contains a co-ordination-of-benefits provision and won't duplicate benefits paid by another policy. A group plan, such as Blue Cross and Blue Shield, may not permit double recovery if the cancer insurance is also a group plan but might pay claims if the cancer insurance is an individual policy.

*Changing Times* also noted uncommon waiting periods or exclusions:

Many, if not most, cancer policies pay only for "definitive cancer treatment." This means that nothing is paid for ailments caused or complicated by cancer or cancer treatment, for rehabilitation or post-treatment checkups, or for diagnosis and pathology reports. Some companies do not mention this in their marketing materials. Others do not explain what definitive cancer treatment is.

Often, radiation and chemotherapy treatments, if covered at all, are paid for only if administered during a hospital stay, even though such treatments are usually given on an out-patient basis.

With many cancer policies malignancies discovered during the waiting periods—which generally run from 60 to 120 days—are excluded altogether or are not covered for up to two years. Most regular health insurance policies do not become fully effective immediately after purchase, but if certain illnesses occur before they take effect, benefits will be paid after the waiting period ends.

Here are some of the other practices that authorities regard as deceptive or confusing:

- Playing up "extended benefits" for hospital confinement of over 90 days without mentioning that such confinements are extremely rare (the average stay for cancer patients is 14 days).
- Implying that a person can collect from two or more policies, even though this is not always true.
- Failing to disclose policy limitations and exceptions.
- Exaggerating the incidence of cancer and the cost of treatment.
- Accentuating benefit maximums that are unlikely to be paid to anyone.

The report also quotes an official of the Federal Trade Commission as saying that cancer insurance is like a lottery ticket and "not a very good gamble, either."

DECEMBER 17, 1979, NEWSWEEK

*Newsweek* began its December 17, 1979 article entitled, "A Premium on Fear" with the following paragraph:

The jovial insurance salesman who appeared at the housewife's door in Plymouth, Mass., had a grim message. Pointing toward a nearby nuclear power plant, he said, "Living

so close to a reactor, you really ought to do something to protect your family." The product he was pitching: an insurance policy to cover her loved ones in case they got cancer. The woman turned the salesman away, but the implications of his pitch left her in tears.

The article continues in part:

[D]ire statistics, critics note, are bandied about without qualifications. Salesmen, they say, neglect to mention that the risk of cancer varies widely in different areas of the country and within different age groups. To lend authority to their sales pitches, some agents cite the American Cancer Society as the source of their data, but they don't mention the fact that the ACS officially opposes cancer insurance.

Many policies, for example, offer nearly total coverage for hospital stays longer than 90 days. The hitch is that most cancer patients leave the hospital within two weeks. Most of the policies don't cover diagnostic tests leading up to hospitalization or chemotherapy and radiation treatments after the patient goes home. Some policies imply that they will pay even if a service is covered by other health insurance. Usually, however, health insurers don't permit "double benefits" of this kind.

*Newsweek* concluded:

The fine print translates into high profits for the insurers. Generally, large insurance companies pay out 80 to 85 cents in benefits for every dollar taken in from premiums. But the loss ratio for American Family Life, which devotes 80 per cent of its business to cancer insurance, was only 43 cents, according to the 1978 Argus Guide, an insurance-industry publication.

#### IV. MARKET CONDUCT EXAMINATION OF FOUR MAJOR CANCER INSURERS

The most detailed and impressive State investigation of cancer insurance was undertaken by Massachusetts. Former Commissioner James M. Stone set forth an ambitious plan. He asked that the largest sellers of cancer insurance in Massachusetts be identified and that a "market conduct" examination be undertaken. A market conduct examination is an in-depth study of a company's operations, including an evaluation of their compliance with State law, their accounting and administrative procedures, and their services to policyholders. It generally entails an examination not only of a company's operations in a particular State but also an evaluation of its home office. The companies selected included three of the four largest in the field nationally: Union Fidelity Life Insurance Company of Trevese, Pennsylvania, American Family Life Assurance Company of Columbus, Georgia, American Income Life Insurance Company of Indianapolis, Indiana, and Washington National Insurance Company of Evanston, Illinois.

Commissioner Stone contracted with major accounting firms to help with these full scale audits. Coopers and Lybrand helped undertake the Washington National and American Income studies. Price Waterhouse and Co. and RL Associates, Inc. helped with the American Family audit, and Touche Ross and RL Associates teamed up for the Union Fidelity work. The work was distributed among these several nationally recognized firms as a means of expediting the examinations and to avoid charges of prejudice.

These four studies were augmented by the work of the Research and Education staff of the Department which sent investigators into company offices. The resulting data was fashioned into a scathing overview report which is summarized at the end of Section V of this report.

What follows is a summary of each of the four market conduct examinations listed alphabetically. These studies have greater importance than the fact that they are the first and most comprehensive of their kind. State insurance regulations have more similarities than differences. The policies which were analyzed in Massachusetts are the same ones, for the most part, which are being sold by the companies in other States. Therefore, the conclusions reached in Massachusetts would likely be valid if the same studies were done in any other State of the Union. For the sake of clarity, emphasis has been added to bring out major points.

## MARKET CONDUCT EXAMINATION: AMERICAN FAMILY LIFE ASSURANCE COMPANY<sup>1</sup>

On February 5, 1979, the Massachusetts Insurance Department released an examination report of American Family Life Assurance Company, a firm based in Columbus, Georgia which sells life and accident and health insurance. The examination concentrated on the company's CancerCare and hospital indemnity policies.

The examination team "was composed of representatives from Price Waterhouse & Co., who addressed those areas which required accounting expertise, William T. Baldwin, Esquire, who addressed those areas which required legal expertise and RL Associates, Inc., who performed market research activities."

The three-part report which disclosed a host of serious violations of Massachusetts law is summarized below.

### (1) *RL Associates Study*

In the introduction to its portion of the market conduct examination, RL Associates explained the purpose of their study:

The Massachusetts Division of Insurance, as part of its audit of American Family Life Assurance Company, decided to incorporate actual testimony from policyholders. The Division at this time is particularly concerned with the sales practices of companies who sell the so-called "dread" disease or cancer coverage policies. The Division believed that the testimony of actual policyholders would provide greater depth to its understanding of the actual knowledge, behavior, and understanding of consumers and the role that the insurance companies themselves play in the education of consumers . . . This report presents findings only from the actual surveys conducted among policyholders.

RL Associates discovered that American Family is the largest company in the field of dread disease or cancer insurance. It sells few, if any, policies through the mail. Its agents either sell policies door to door or at job locations using the implied endorsement of the employer.

A sample of American Family CancerCare or intensive care policyholders was drawn by the company from its own records. It included every person who had purchased such policies from American Family in the State of Massachusetts during the period January 1 through July 31, 1978. A subsample was randomly selected and interviews were carried out by professional interviewers during the early part of November 1978.

Among the major findings of the study were as follows:

---

<sup>1</sup> American Family prepared a detailed presentation which they offered to the California, Massachusetts, and North Carolina Commissioners as well as to this Committee. The presentation is carried on pages 150-180 of the Committee's publication 95-165, a November 28, 1978 hearing entitled, "Abuses in the Sale of Health Insurance to the Elderly." See also summary of American Family's comments at page 54 and following, of this report.

- **American Family sells policies either door to door or through employers at the place of employment :**

Roughly half of those who know they own a cancer policy bought it at their place of employment. The great majority of these people think the policy is endorsed by their employer, but conversely only one in five thinks it is a part of their benefits package. Finally, seven out of eight pay for the policy by payroll deductions. Thus, respondents appear to have a fair understanding of the relationship of American Family to their employers. It is certainly reasonable to think that if an employer first allows an agent to sell at the job location and then deducts the premiums from payrolls, that the employer is "endorsing" the policy and most respondents know that they and not the employer are paying for the policy. Whether such an implied endorsement is legal is for the lawyers to decide, especially in the many cases where the employer is a unit of local government. For instance, a very large part of the sample worked in some way for the town of Marlboro (Massachusetts).

- **Many American Family policyholders were elderly :**

The median age of those individuals who purchased a policy in their homes is close to 70.

- **Since a significant number of those who purchase the policies are elderly a serious problem exists with "coordination of benefits:"**

Coordination of benefits means that payments on one policy, i.e., Blue Cross/Blue Shield will be reduced to prevent double recovery upon learning that the individual has a second policy which will help pay claims.

Since virtually everyone in the sample over 70 is covered by Medicare and three-fourths have Blue Cross/Blue Shield coverage as well, it is probable that there is a significant problem of coordination of benefits.

- **American Family agents do not generally know their clients before the sale :**

Only one in 15 knew the agent before (the sale) and most have never seen the agent again. Apparently, American Family agents sell the policy and go on to the next sale.

- **American Family agents always use sales brochures :**

Three out of four respondents have seen or read a brochure. By far, the single largest area of recall as to what the brochure said dealt with the increasing cost of cancer.

- **Fear of cancer or the cost of cancer were the primary motivation in the purchase of a policy :**

The policyholders chose American Family because "it was the only policy they had heard of, because it was recommended or because of the influence of the agent."

At least some of this information about incidence had come from the agent. Three-fourths of those who bought through

an agent said he had mentioned that "1 out of 4 Americans will eventually get cancer," while almost as many said he had mentioned that "breast cancer strikes more women than any other form of cancer."

- Even though purchase was motivated by fear of cancer and its costs, most American Family policyholders had little knowledge of what the policy would pay should a cancer attack occur:

Most respondents do not even claim to understand the potential benefits of the policy. Two-thirds of those who claim to have cancer policies do not know what fraction of either a \$20,000 or \$2,000 cancer bill would be paid on average. Of those who do think they know, substantial majorities say all of the bill. Majorities of respondents also do not know whether the policy pays each of five specific benefits.

- Most of those who had an American Family intensive care policy did know they had one and did not understand it as a separate policy and not of their cancer policy:

Only 15 percent of all respondents said they had an intensive care policy with American Family. Their records indicate a much higher percentage.

RL Associates summarized their study as follows:

**American Family sells cancer policies in two ways: by door-to-door sales to predominantly older people who are in their 60's and 70's, and to younger people at their place of employment.**

**In both cases, their policyholders are not particularly well informed as to the benefits of the policies, and in many cases also have overlapping coverage with Blue Cross/Blue Shield and/or Medicare.**

**American Family's agents are clearly more interested in presenting the horrors and catastrophic costs, real or imagined, of cancer than they are in describing the likely real benefits of the policies they sell.**

(2) *William T. Baldwin: Legal Analysis*

William T. Baldwin is an attorney with the firm of Marullo, Baldwin, Frieden, Gatewood and Linder of Boston, Massachusetts. Mr. Baldwin is an expert in insurance law and he was asked to study the compliance of American Family Life Assurance Company with Massachusetts laws and regulations. His report charges serious violations with respect to policy forms and marketing brochures, with respect to agents licensing and training, with respect to sales practices, complaint services and claims payment procedures. His report is summarized below.

A. SHORTCOMINGS IN POLICY FORMS AND MARKETING BROCHURES

In summarizing this section of his report, Attorney Baldwin says:

**The brochures used in selling cancer insurance appear to be inadequate, deceptive and misinformative. The inci-**

**dence and cost of cancer, rather than the benefits or coverages, are used as the primary selling tool. The description of benefits payable fails to provide sufficient relevant information about the policy. The brochures also fail to disclose some of the limitations in the policy and the likelihood that coordination of benefits by other policies will apply.**

The report points out that sales brochures play a very important part in the company's sales programs. Virtually all sales are made by agents whose primary selling tool, other than his sales pitch, is the brochure. It is common for the agent to stamp his name on the back of the brochure along with address and telephone number which can then be left with purchasers. . . .

A common thread which runs through all the brochures is the use of a "Cancer Will Strike" sheet. Says the report, this "strike sheet" uses silhouetted figures of women, children, families and people in general to illustrate cancer statistics. Beneath the silhouettes is a statement of cancer statistics citing the American Cancer Society's report, *Cancer Facts and Figures* :

The next common theme is some form of presentation regarding the debilitating costs of cancer treatment. Fear of the cost of cancer may be the single most significant factor in influencing individuals to purchase this insurance. In evaluating the specific harm that arises from an appeal to the emotions, it must be remembered that such appeals do not lead the consumer to make a decision upon a rational basis.

Source: '78 Cancer Facts & Figures - American Cancer Society  
Use of this information does not imply endorsement of this policy.

# CANCER

will Strike...



WITHIN A LIFETIME

1 in every 4 AMERICANS



2 of every 3 FAMILIES



## CHILDREN

Leukemia is the leading  
killing disease of School  
Age CHILDREN



## WOMEN

Cancer is the leading serious disease of WOMEN  
age 30 - 54

88,000 WOMEN will develop Breast Cancer  
this year


231,000 WOMEN will develop Cancer this year

## MEN

Lung Cancer in MEN has increased 2,000%  
Since 1930

334,000 men will  
develop Cancer this year



CANCER <sup>\$</sup>   
IS GETTING  
MORE COSTLY

Americans spent for the cost of  
cancer during

1962 ..... Approximately 1.25 Billion  
1972 ..... Estimated \$2 Billion  
Estimated 160% increase in 10 years

### BASIC BENEFITS

All limits shown are lifetime limits for each person covered.



**HOSPITAL CONFINEMENT** - \$60 daily first twelve days, \$40 per day thereafter. Readmission 30 days after discharge starts \$60 daily payment again. No limit on number of confinements.



**DRUGS & MEDICINE** - Actual expenses to 15 percent of the total payable Hospital Confinement benefit for drugs and medicines administered in hospital and charged to Insured.



**CONVALESCENCE** - \$15 per day for each day insured is eligible for \$60 per day Hospital Confinement benefit.



**SURGICAL** - Fee charged to amount shown in Schedule in Policy. Hospitalization not required. Limit \$30 to \$750. No limit on number of operations.

**PHYSICIAN** - Actual expenses to \$10 a day in hospital for physician other than surgeon. Limit \$900.

**PRIVATE NURSING** - Actual expenses to \$25 a day in hospital, as required, for R.N. or L.P.N. Limit \$750.

**RADIOTHERAPY & CHEMOTHERAPY** - Actual expenses to \$1,500 for X-ray, Radium, Cobalt, Therapy and Chemotherapy. In or out of hospital. Excludes diagnostic procedures. Limit \$1,500.

**ANESTHESIA** - Actual expenses for professional fees up to amount shown in policy schedule. Limit \$30 to \$225. No limit on number of operations.

**BLOOD & PLASMA** - Actual expenses to \$700 for charges made to Insured. No limit on Leukemia. Limit \$700 for other cancers.

**AMBULANCE** - Actual expenses to \$50 each confinement to and from hospital where Insured admitted as patient. Limit \$600. Any qualified ambulance may be used.

**GOVERNMENT HOSPITAL CONFINEMENT** - \$40 per day for first 30 days; \$30 per day thereafter. No other benefits are payable while confined in a government hospital.

### EXTENDED BENEFITS

**HOSPITAL CONFINEMENT, DRUGS & MEDICINE** 100% of the actual charges made by the hospital for care and treatment up to \$6,000 per month beginning with the 91st day of continuous confinement until discharged from the hospital.

NO DEDUCTION FOR BENEFITS PREVIOUSLY PAID BEGINNING WITH THE 91st DAY  
FOR EXTENDED BENEFITS THERE ARE NO LIFETIME DOLLAR MAXIMUMS NOR TIME LIMITS

### THIS IS A CANCER ONLY POLICY Form A-7481

AND SHOULD BE VIEWED AS A SUPPLEMENT  
TO YOUR PRESENT HEALTH INSURANCE

#### OTHER INSURANCE

This Policy is intended to supplement your existing health insurance program to better provide for the personal expense of Cancer treatment. The policy contains no provisions reducing benefits because of Medicare or any group or individual insurance you may carry. However, only one policy on this plan will be issued to any individual.

#### PAYS TO YOU

This is your insurance. Its benefits are paid directly to you or to the hospital or physician, as you direct.

#### GUARANTEED RENEWABLE

Premium Adjustable by Class  
This Policy can be renewed only by the Insured. The Policy is renewable for life, at then-current premium rates. Rates may be changed only if changed on all like policies in force in your class.

#### INDIVIDUAL OR FAMILY COVERAGE

FAMILY includes the Insured, Spouse and dependent unmarried children to age 21 or to age 23 if a full time student.

#### ALTERNATE HOSPITAL CONFINEMENT BENEFIT

You may elect to receive the following benefits in lieu of the basic and extended benefits.

First 30 days hospitalized, \$2,500 per month -  
daily rate of \$83.33

Next two months hospitalized, \$2,000 per month -  
daily rate of \$66.67

All additional months hospitalized, \$1,500 per month -  
daily rate of \$50.00

#### LIMITATIONS & EXCLUSIONS

This Policy provides benefits only for loss resulting from definitive cancer treatment. Positive pathologic proof of diagnosis is required. Other diseases and accidents are not covered.

Benefits are not provided in nursing homes, or extended care facilities. Government hospital confinement benefits pays only the daily rate shown; no other benefits are payable for such confinement. This Policy does not provide any coverage for a person who has had cancer diagnosed prior to the effective date of the policy, or who has cancer diagnosed during the 60 days after the effective date of the policy.

#### AGE & HEALTH

This insurance may be purchased by anyone of any age in any state of health who has never had Cancer.

#### EFFECTIVE DATE OF POLICY

Effective Date of this Policy is the date the policy is issued by the Home Office.

#### PREMIUM RATES

	Premium Rates	
	Ann.	Semi Ann.
L-1 DIRECT		
Individual	\$50.00	\$26.00
Family	\$75.00	\$38.50

# Why This CancerCare Plan?

## 1. WHY DO I NEED CANCER INSURANCE?

The National Cancer Institute reports that Cancer will strike two families of three during their lifetime and this disease is the leading cause of death in women from ages 30 to 54. Overall, Cancer is the second leading cause of death of all age groups. Cancer is often a lingering disease which requires expensive treatment and relapse in the victim's being unable to work. This policy should be viewed as a supplement to your present health insurance.

## 2. WHAT MEDICAL INFORMATION DO YOU NEED?

The only medical question is whether you have had Cancer positively diagnosed. If not, you may buy the policy.

## 3. CAN THIS POLICY BE CANCELED BY THE COMPANY?

No. The only way this policy may be canceled is through the insured's not paying the premium.

## 4. MUST I BE HOSPITALIZED TO RECEIVE BENEFITS FROM THE POLICY?

No. As shown in the benefits description, Surgical, Radiation, Chemotherapy, and Blood and Plasma benefits are provided without regard to where the service is rendered.

## 5. WHEN DOES THIS POLICY BECOME EFFECTIVE?

Coverage under this Policy begins 60 days following the effective date of the policy for cancer diagnosed after that date.

## 6. WHAT BENEFITS DO I RECEIVE FOR DRUGS AND MEDICINE?

You will be reimbursed for actual charges made by the hospital for the drugs and medicines prescribed by the attending physician not to exceed 15% of the benefits provided for Hospital Confinement.

## 7. IF THERE IS A HISTORY OF CANCER IN MY FAMILY, MAY I STILL PURCHASE AND AT THE SAME PREMIUM?

Yes. It has been our experience that those most closely related to the expense of Cancer are the most anxious to secure this type of insurance. Those family members who have had cancer are not eligible, and will be excluded.

## 8. WHAT IS THE AGE LIMIT ON PURCHASE OF THIS POLICY? WHAT EFFECT DOES AGE HAVE ON THIS POLICY?

This insurance may be purchased by anyone of any age in any state of health who has never had Cancer. Benefits are provided regardless of age, and you may continue your policy for the rest of your life.

## 9. MUST I BE RELEASED FROM THE HOSPITAL BEFORE THE POLICY PROVIDES BENEFITS?

No. Benefits are available to the insured as the expenses are incurred, on a monthly basis if he chooses. Release from the hospital, or from a doctor's care, is not necessary for you to begin receiving benefits.

## 10. DO BENEFITS ACCRUE DIRECTLY TO ME OR THE HOSPITAL?

Benefits from this policy may go directly to the insured, the hospital or the physician, as you direct.

## 11. WHAT IS MEANT BY POSITIVE PATHOLOGICAL DIAGNOSIS OF CANCER?

It is a microscopic examination of human tissue or fluid by a pathologist to determine if there is a positive malignancy.

## 12. WHAT FORMS OF CANCER ARE COVERED?

All Cancer diagnosed as such by a pathological examination, a standard medical practice, including leukemia and Hodgkins disease.

## 13. WHO IS INCLUDED ON A FAMILY POLICY?

The insured, spouse and dependent unmarried children to age 21, or to age 23 if full-time students. (Unmarried dependents continued as provided by statute.)

## 14. WHAT TREATMENT IS COVERED BY THE POLICY?

X-ray and radium therapy, radio colloid and other radioactive isotopes, chemotherapy and surgery are covered by the policy. (Diagnostic x-ray and other diagnostic procedures are expressly excluded from the policy.)

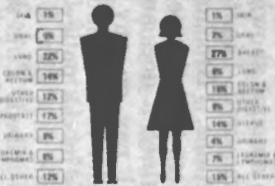
## 15. DOES THIS POLICY COVER ME IN A NURSING HOME OR AN EXTENDED CARE FACILITY?

No. These institutions are not included in the classes of organizations recognized as hospitals for the purposes of this policy.

## 16. IF I AM HOSPITALIZED TWICE OR MORE IN A YEAR, HOW MUCH WILL THE POLICY PAY ON MY HOSPITAL EXPENSE?

The number of hospitalization periods in a year makes no difference at all in the payment of claims excepting that if thirty days or more separate two successive periods of hospitalization, the hospital confinement benefit is at the \$60 a day rate for the first twelve days of the second confinement as if no previous confinement had occurred.

### CANCER INCIDENCE BY SITE AND SEX



# CANCERCARE

By

**American Family Life  
Assurance Company  
of Columbus**

1600 Medical Plaza, Columbus, Georgia 31906



1600 Medical Plaza, Columbus, Georgia 31906

Circle 6 on Reader Service

He adds:

The statements regarding the cost of cancer are not very specific, ranging from "Cancer Is Getting More Costly" (Brochure A-7302), to a discussion of the "economic considerations of cancer treatment" (Brochure A-8195). The only statistics cited in brochure A-7302 are for the overall cost of cancer treatment nationwide, 1962 to 1972. Similarly, the "Economic Considerations" approach contains considerations that apply equally as well to any type of disease. The considerations cited are indirect expenses, travel to another city for treatment, and disability of a wage earner. The most important consideration for the customer buying insurance is that he make a rational decision based upon the facts. The economic argument set forth in the brochure, which bears no more relationship to cancer than to any other type of illness or injury, is not relevant . . . The primary emphasis in the Company's policy brochures is on the above-described elements of cancer incidence and health care costs.

Other aspects of the brochures were found to be misleading as shown below.

- The schedule of basic benefits in the brochures that are applicable to surgery is misrepresented. Says Baldwin:

The fee charged to amount shown in schedule and policy. Hospitalization not required. Limit \$50—\$500. No limit on the amount of operations. (Brochure A-7303) This would indicate to most readers that the policy pays for the cost of surgery up to \$500, which it does not. In order to determine what the policy will pay on any specific procedure performed, one has to refer to the policy's "Schedule of Operations," which appears in the policy itself. A closer analysis of that schedule reveals that \$500 will be paid for only 4 of the 34 operations described. This schedule is not long and it could be easily included as part of the brochure without eliminating any other useful information. In order that the consumer may make an informed evaluation of the policy, it should be stated what costs are likely to be incurred that are not covered by the policy. Otherwise, a buyer might feel that the schedule of benefits is comprehensive. Blue Cross-Blue Shield of Massachusetts uses this approach in the brochures describing their MEDEX policies. Bar graphs indicate the expenses which are covered by the MEDEX Medicare supplement policy, and those remaining to be paid by the individual.

- The brochure also fails to explain what percentage of the total medical costs the Company's policy would pay on the average if cancer were to strike. "A random sample of claims selected by the auditors reveals that the company did in fact pay an average of 23.4 percent of charges."
- The Company's advertising material fails to mention that: the policy benefits may be subject to coordination by other policies

of insurance. Brochure form A-6437 contains a section dealing with coordination of benefits which states :

**OTHER INSURANCE**

This policy is intended to supplement your existing health insurance program to better provide for the unusual expenses of Cancer; therefore, the policy contains no provisions reducing benefits because of Medicare or any group or individual insurance you may carry. However, only one policy on this plan will be issued to any individual.

Under Massachusetts General Laws ch. 93A, section 2 and the Attorney General's Regulations, it is incumbent upon one who is selling a product or service to disclose all relevant information to the consumer which he would need to make a rational, informed decision. The regulations promulgated under ch. 93A have held that the seller cannot protect himself from charges of unfair or deceptive practices by merely remaining silent. Instead, the failure to disclose facts which, if known to the buyer, would have influenced him not to buy constitutes an unfair and deceptive trade practice and therefore is a violation of that statute. The Company fails to make such disclosure on any of its policy brochures. Brochure A-6437 broaches the subject of coordination. In the section quoted above, the brochure tells a half-truth, thereby misrepresenting the value of the policy. When it states that the policy does not coordinate benefits it should also state whether the opposite is true, whether it may be coordinated against. The latter information is just as relevant as the former.

The report charges that form A-7011 is misleading :

Brochure form A-7011 is entitled "Care Program, a supplement to your present health and life insurance." It sells three policies, "Cancer Care" (A-6021), "Intensive Care" (A-4696) and "LifeCare" (A-5191). The overall format of the brochure suggests that these three policies, when taken together, fully supplement the consumer's present health and life insurance. The consumer who buys the whole package may construe its coverage in the normal sense, thinking that it picks up where his other Major Medical leaves off, while in fact it only provides benefits for cancer, time spent in an intensive care unit, or death.

The report summarizes with these comments with respect to American Family's brochures :

The use of the above described brochures constitutes an apparent violation of ch. 93A, section 2. By excessive appeals to the emotions aroused by the fear of cancer and its costs, and the failure to clearly outline the benefits and drawbacks of the policy, consumers are induced to buy without the facts necessary for a rational decision. The misleading reference to coordination of benefits stands out as an obvious violation of that section. Interviews with insureds reveal that they

have retained more information about the incidence and cost of cancer than about the benefits provided by the policy.

The following recommendations are made in order that the brochures not be misleading and provide more useful information to the consumer:

- Eliminate the “Cancer Will Strike” sheet on all policies;
- Disclose the existence of coordination of benefits provisions that are contained in Massachusetts’ master medical plans;
- Eliminate use of the “Care Program” brochure; and
- Disclose benefits in such a way that the consumer may evaluate the benefits before filing a claim.

#### B. POLICY FORMS VIOLATE STATUTES AND REGULATIONS

Baldwin summarizes this section of his report:

**The two policy forms which are analyzed in detail are the “CancerCare” and the Cancer Hospitalization Indemnity Policies. Both policies are in apparent violation of statutes and regulations by virtue of their format and definitions or lack thereof when such definitions are required to be stated or are prescribed by regulation. Further, these policies provide for increases in premium in an apparent violation of the regulations which prohibit such increases for specified disease policies. These policies should be reviewed and recommendations for changes made.**

##### *1. Analysis of Form A-6021—The “CancerCare” Policy*

Baldwin points out that this, the most popular American Family cancer policy, incorporates the following limitations:

- (1) Waiting period of 90 days.
- (2) Extended benefits are not to exceed \$5,000.00 per month.
- (3) When cancer is diagnosed subsequent to treatment, but while the insured is living, benefits are payable beginning with the later of:
  - (a) the first day of hospital confinement during which such diagnosis is made, or
  - (b) ten days prior to diagnosis.
- (4) When cancer is discovered by post-mortem diagnosis, benefits are payable beginning with the later of:
  - (a) the date of terminal admission, or
  - (b) 45 days prior to death.
- (5) A positive pathology report is required, clinical diagnosis is not sufficient.
- (6) The policy covers cancer only.
- (7) The policy does not pay for treatment in Veteran’s Hospitals, rehabilitation homes, mental institutions, sanitariums, nursing, convalescent homes or other extended care facilities.

The report concludes:

- The policy marketing brochures and sales approach fail to reveal the existence of limitations numbered (3), (4), (5) and (7). Such failure to disclose a material fact constitutes an apparent violation of ch. 93A, section 2.
- Regulation section 5, paragraph 32 requires that for all specified disease coverage the policy premium shall not be subject to premium increases. On page 4 in the section entitled "Renewal Provision," the Company retains the right to raise the premium for all policies of a type within the state upon 30 days notice to the insured.
- Under the basic benefits section the policy defines "continuous confinement" as discharge and readmission within 30 days. Under the Extended Benefits section there is no applicable definition. Regulations section 6 (A) requires the definition to state that discharge and subsequent admission for the same cause may occur within 90 days and still qualify as "continuous confinement."
- There is also an apparent violation of Chapter 175, Sec. 108 part 2(a)(5) which requires that all exceptions "... and reductions are to be collected under one heading labelled either 'Exceptions' or 'Exceptions and Reductions.' There is a section labelled 'EXCEPTIONS AND LIMITATIONS,' but it does not contain the post-mortem diagnosis, VA Hospital and other exceptions or reductions contained elsewhere in the policy."

2. *Analysis of Form A-8011, The Cancer Hospitalization Indemnity Policy*

Baldwin points out that this policy was designed to avoid the problems resulting from coordination of benefits provisions in other policies:

It seeks to achieve this result by indemnifying the claimant, not for any specific line items of insurance, but by payment of a sum based upon the number of days the claimant is hospitalized.

Policy A-8011 pays \$100 per day, not to exceed \$3,000 per month, for continuous periods of hospital confinement up to 90 days. Over 90 days, the Company pays \$200 for each day of continuous hospital confinement. The primary limitations in this policy are:

- (1) The requirement that confinement be continuous for 90 days for extended benefits to apply.
- (2) The 60 day waiting period.
- (3) A positive pathology report is required, clinical diagnosis is not sufficient.
- (4) When cancer is diagnosed subsequent to treatment, but while the insured is still living, benefits are payable beginning with the later of:

- (a) the first day of hospital confinement during which such diagnosis is made, or
- (b) thirty days prior to diagnosis.
- (5) When cancer is discovered by post-mortem diagnosis, benefits are payable beginning with the later of:
  - (a) the date of terminal admission, or
  - (b) 45 days prior to death.
- (6) The policy does not pay for the treatment in Veteran's Hospitals, rest or rehabilitation homes, mental institutions, sanitariums, nursing or convalescent homes or other extended care facilities.

The report concludes that the "following apparent violations of Insurance Regulation 2-74 are found to exist in form A-8011:

- The policy provides that the premium may be raised by policy type, statewide, upon 30 days notice to the insured. This is an apparent violation of Regulation 2-74, section 5, paragraph 32, which prohibits such increase for specified disease policies.
- There is no definition of 'continuous hospital confinement' as is required by Regulation 2-74, section 6(A).
- Policy form A-8011 also contains an apparent violation of Chapter 175, section 108, part 2(a) (5) which requires that all exceptions and reductions are to be collected under one heading labelled 'Exceptions and Reductions.'

### *3. Shortcomings in Policy A-4797*

Yet another policy examined was the A-4797 policy also known as CMP-2 written as a group insurance policy. This policy together with a CMP-2 certificate was issued to the Brandeis University National Womans Committee as a group. With the endorsement of that group, the policy was marketed to organization members in several States. Summarizing this violation of Chapter 175, Section 108 of the Massachusetts General Laws, Mr. Baldwin wrote:

A group policy of insurance has been sold to an organization in such a manner that it does not qualify as a group policy under the definition provided by Massachusetts law. These issuances are therefore of individual policies of insurance, which have not been reviewed by the Massachusetts Division of Insurance. Certificates of insurance under this policy are marketed nationally, based upon the premise that they are issued pursuant to a Massachusetts group plan.

### *4. Shortcomings of Penn. FIC-2 and FIC-2A Policies*

The report says that these "individual policies" have been sold by direct mail to Massachusetts Postal Workers. Comments the report, "This is not a group policy, nor has the policy form been submitted to Massachusetts for approval. The selling agency is not licensed to do business in Massachusetts."

### *5. General Criticisms Applicable to All Policies: Promised Extended Care Benefits are Illusory and Deceptive*

Says the report:

With respect to all policies paying extended or increased benefits after 90 days of continuous confinement (all of the policies discussed above do so) such benefits are illusory because of the short average duration of the cancer victim's stay in the hospital. From an analysis of 1 of every 5 Massachusetts paid claims and 35% of claimants who were paid during the subject period (1/1/77-6/30/78), no claim resulted in payment of extended benefits to the policyholder. The average number and median number of days of confinement for each claim is 9 days, and the average confinement for all in-patient claims is 13.2 days. A stratification of the claims selected illustrates that of the 85 claims examined, no claimant qualified for extended benefits. In fact, none of the continuous confinements exceeded 90 days, and in only one case did confinement exceed 30 days.

This is a material fact relating directly to the value of the benefit in the policy which is used as a selling point. Use of such an illusory benefit tends to be deceptive and therefore constitutes an apparent violation of ch. 93A section 2.

#### C. LOSS RATIOS: HIGH PROFITS AND COMMISSIONS BUT LOW ECONOMIC VALUE

The report comments about American Family's cancer insurance policies and the percent of premium dollars returned to the insured in the form of claims:

**The policy is a high markup, low value item. Commissions range from over 50% to a low of 13% of first year premiums, and the loss ratios are less than 50% overall. The Company's policy has been to increase premiums when loss ratios exceed 50%.**

Says the report:

The policies provide that an increase may be made, state-wide by policy type, in an apparent violation of Regulation 2-74, section 32, which prohibits increases in the price of specified disease policies.

#### D. COORDINATION OF BENEFITS: A PROBLEM FOR AMERICAN FAMILY POLICYHOLDERS

As the report notes:

Coordination of benefits is the process by which an insurer will reduce or eliminate his liability for reimbursement of a specific line item cost because that particular line item is also covered by another insurance policy. American Family sells its insurance on the principle that their coverage may very well exceed the gap left by other medical coverage. This is said to be desirable because of the costs of illness that are not represented on the hospital bill, such as lost wages, travel expenses and so on.

However, what is likely to happen is that the purchase of an American Family policy will cause Blue Cross/Blue Shield or other insurers to reduce their payments to prevent the insured from receiving more than his medical costs in insurance payments.

The report quotes the Massachusetts state manager of American Family as saying coordination of benefits has cost him "60 to 80 agents" because other companies have stated that they would coordinate against American Family's policies when this becomes known. The state manager says this discourages sales or causes policy cancellations. The report comments:

It is clear that coordination of benefits is a very real problem for American Family policyholders. The provisions of the Blue Cross-Blue Shield contract will cause coordination. Blue Cross-Blue Shield coordinates against other policies on the basis of "item(s) of service or care." It is argued that the A-8011, Hospitalization Indemnity Plan, will not be coordinated against because it does not refer to specific items of service or care. However, the provisions of Blue Cross-Blue Shield's contract admits to no such restrictions. They might, if challenged, argue that the hospital's total bill represents a charge for an item of service or care. To the extent that Blue Cross-Blue Shield coverage exceeds the total bill, coordination could apply. Because this provision can cost the policyholder a loss of benefits, failure to inform the insured of the existence of coordination of benefits constitutes a violation of 93A, section 2 and the Attorney General's Consumer Protection Act Regulations, section XV B.

#### E. AGENTS LICENSING AND TRAINING

Attorney Baldwin summarizes this section of his report:

The Company's sales training program appears to be deceptive and utilizes high pressure, low information techniques. Training conducted for purposes of the State licensing examination appears to be woefully inadequate. All training for the licensing exam and most of the sales training is conducted by commissioned salesmen in the field. No records of attendance or performance are kept by them. The sales technique taught is subject to many of the same shortcomings as the policy sales brochures. It overemphasizes the incidence and cost of cancer, while not providing sufficient relevant information regarding benefits.

Past practices of the Agent's Licensing Department appear to have been inadequate. Recently instituted procedures of that department show an improvement in the manner in which applications are examined, and qualifications and references are checked out. These newly instituted procedures should be followed and applied to all phases of record keeping and follow-up in that department.

A review of files in the Agent's Licensing Division revealed significant shortcomings. The files were incomplete. Some forms were blank and often there was no personal history information. In half of the cases, there was no credit-check on applicants. The report says:

The qualifications of the new agents as shown by the files are such that they would indicate that there are no mini-

**mum standards for hiring. The files show nine instances in which the company's agents applied to the Commonwealth of Massachusetts for a license to sell the company's insurance before their application to the company was approved. Training certificates are not found in the majority of files. Only one out of the 13 files examined indicated that the agent had any prior experience. No independent investigative report was filed in 11 of the 13 files examined.**

**Noting that there have been some recent improvements in Massachusetts, the report concludes:**

**These conditions indicate that the Company has in the past not adequately investigated the background of its agents in Massachusetts, nor has it required adequate proof of proper training. The practices followed by the Agency Licensing Department indicate that all matters such as the screening of applicants, the training of those applicants for licensing exams and the activities of agents are left to the state and district managers to deal with as they see fit.**

**With respect to training procedures, the report notes these shortcomings:**

**Training for the state licensing exam is carried on in the field without any supervision or review by the company. No records are kept of attendance or performance. Training for the exam is entirely separate from the sales training program.**

**The program is geared toward training the agent to sell the product. No emphasis is placed upon training the agent about insurance. The sales program is designed to allow the agent to make a presentation while thwarting any attempt on the part of the customer to protest or ask meaningful questions. The presentation itself is basically the same information as is contained on the sales brochures.**

**The agent is instructed how to be forceful and evasive so that he can get into the house of an unwilling prospect without letting the prospect know what he is selling. The agent is instructed, when faced with the initial question, "is it insurance?" to "take charge at this point—be strong! be positive!" and reply "What I have to tell . . . I also need to show you . . . It will only take a few minutes . . . May I come in?" If the prospect indicates that he or she has sufficient insurance, the agent is to explain ". . . we don't have any insurance. The doctor who treats you has insurance his bills will be paid. The hospital has insurance its bills will be paid. But, in reality, you do not have any insurance." The agent is instructed to state that the policy only costs 21 cents per day, to combat the protest that the buyer doesn't have any money. Finally, the salesman is instructed to utilize the statistics from the (cancer will) strike sheet as "additional ammunition" whenever needed.**

**Concludes the report:**

*The Company's sales training program is unacceptable because of the violations of Consumer Protection Regulations*

*pursuant to M.G.L. 93A, dated July 1, 1971. Section VIII of those regulations, entitled Door to Door Sales and Home Improvement Transactions, states:*

“In connection with any door to door sale, it constitutes an unfair or deceptive act of practice for any seller to:

A. At the time of initial contact, and before making any misrepresentations or fail to state any material fact which has the capacity or tendency to disguise, hide or fail to inform the purchaser of the purpose of the contract;

B. Make any representation, in the sale, offering for sale, advertising, or distributing for sale, or in any other manner, including the failure to adequately disclose additional relevant information, which has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers with respect to any material aspect of the product or transaction;

C. Fail to disclose the exact nature, description and price of the goods or services which are to be the subject of the transaction to the purchaser or prospective purchaser in advance of any attempt to induce the purchaser or prospective purchaser to enter into (1) an agreement in writing, or (2) to pay any consideration to the seller.

Section XV of the same regulations states that an act of practice is a violation of Chapter 93A, section 2, if:

A. It is “oppressive or otherwise unconscionable,” in any respect; or

B. Any person or other legal entity subject to this act fails to disclose to a buyer or prospective buyer any fact, the disclosure of which may have influenced the buyer or protective buyer not to enter into the transaction.

Being evasive at the door as to the nature of the product being sold is an apparent violation of section VIII, A and B of the Attorney General’s Rules and Regulations (hereinafter, “Regulations”). High pressure techniques are an apparent violation of Regulations, Section XV A, as “oppressive or otherwise unconscionable in any respect . . .” Making a statement to the effect that “we don’t really have *any* insurance” has the capacity to mislead the buyer, in apparent violation of Chapter 93A and Regulations, Section VIII A and B. The use of 21 cents per day as a price for the insurance tends to mislead and constitutes an apparent violation of Regulations Section VIII. When the agent is informed that the prospect has other insurance, the agent should then be put on notice that there may be problems with coordination of benefits, overlapping coverage or overinsurance. To teach agents to purposely fail to meet the issue in any meaningful way constitutes an apparent violation of Regulations Section XB, B.

Baldwin summarizes:

**When sales training is taught entirely in the field, as is usually the case in Massachusetts, the Company has no review over or supervision of the program. What is done or what is not done with either type of training in the field occurs without any input from Company officials. That is the fundamental problem to be corrected. It is recommended that there be salaried personnel at the state level to see that training for licensing and sales training is carried out properly. The overall emphasis of the program must shift from high pressure, low information sales to a sales presentation of an educational, informative and relevant nature.**

#### F. SALES PRACTICES

The report's comments with respect to the Company's sales practices are summarized below:

**Sales are conducted primarily by agent selling, either to cluster groups or individual purchasers at home. Leads are obtained by approaching employers and organizations, or by scanning voter lists for the elderly. The use of peer pressure and the express or implied endorsement of employers, associations or friends is a standard part of the sales technique.**

**The Company does not regulate sales practices. Agents have created sales materials and practices on their own, without company supervision, although the Company was aware that the agents were doing so. Some of the materials used by agents to represent claim payments made in the past and to explain away the coordination of benefits problem constitute misstatements of the policy benefits and drawbacks.**

The report notes that the Massachusetts State sales office works independently from the national office. State and District Managers are allowed to establish whatever practices and methods they see fit. "The use of materials developed by the agents is a practice of which the company has knowledge. The agents contract gives the company the right to restrict the materials used by agents but apparently this right is rarely used." Explains the report, "The natural inclination is to emphasize sales at the expense of all other considerations, while the Company finds it difficult to play the spoiler when it, too, benefits from the increased sales."

Concludes the report:

- The failure of the Company to keep a file of all marketing materials produced independently by its agents is an apparent violation of Regulation 1-74, Section 17 which requires the maintenance of an advertising file.
- The use of the out of state letters regarding coordination of benefits and the inapplicable \$54,000+ claim letter is misleading and therefore constitutes an apparent violation of ch. 93A, section 2.

- Apparent violations of ch. 175, sections 108 and 110 were committed in the course of marketing the Brandeis policies.
- The Post Office Association members were apparently sold policies that were not approved, in violation of ch. 175, section 108 by an unlicensed agent, in violation of ch. 175, section 162.
- The Company apparently exercises little or no control over its agents' practices. By law it is responsible for the acts of its agents, and by the terms of the contracts it retains the right to control the agents' activities.

The report recommends:

[T]hat the Company tighten its system to eliminate the fundamental conflict that exists between sales and compliance. Specifically, agents should be recalled in order that the Company may find out what materials are being used. The salesmen must be educated to use sales techniques that are in compliance with the law. A Company line must be established on such subjects as coordination of benefits, and the agents must follow that line. If the disclosure of coordination of benefits is fatal to the Company's policy, the policy should be re-designed so that it really does fill the gaps left by other major medical policies. If it does in fact fill the gaps left by another policy, as it is advertised to do, then coordination will be of no effect. The point is that problems cannot simply be ignored. The Company must also supervise all direct mail by requiring prior approval of all programs started and changes made. Finally, some sort of compliance testing would be advisable to ensure that agents are performing as they should. Company officials might make trips to cluster sales presentations, or interview persons who were sold policies in their homes, to ascertain that unfair and deceptive practices have been stopped.

#### G. COMPLAINTS, POLICYHOLDERS SERVICES

The following points were noted with respect to the Policyholder's Services Department:

- No record of telephone inquiries is kept.
- The Department does not retain written complaints in a system that would enable retrieval of those complaints.
- The State and District Managers and Agents do not keep records of complaints received by them.
- Claim-related complaints are routed directly to the claims department with no further follow-up by policyholders services.

The report concludes:

Massachusetts General Laws, ch. 176D, section 3(10) requires the Company and its agents to keep a complete record of all the written complaints which it has received since the date of its last examination which shall indicate the total number of complaints, their classification by lines of insurance, and the nature, disposition, and time of processing of each complaint.

Accordingly, the system does not comply with the provisions of ch. 176D, section 3(1). The system maintained by the Company is satisfactory for its own purposes, but additional procedures are recommended to comply with the statute. Complaints received in connection with claims should also be integrated into the record-keeping of the Policyholders' Services Department. That department should remain aware of and keep records with regard to all complaints that are routed to Claims.

#### H. CLAIMS

The report notes that :

[T]he Company attempts to handle claims in as short a period of time as possible. This policy is seen as supportive of sales, where many of the policyholders in payroll deduction groups are in close contact with each other.

Unacceptable rates of error were uncovered in two areas of claims settlement procedures :

- Benefits were not determined in agreement with the policy terms in 16.8% of the sample observed.
- The explanation of benefits letter was incomplete as to additional benefits that were available upon submission of additional documents in 8.2% of the sample.

The report concludes :

A more acceptable rate of satisfactory claims payment procedures could be attained through either the implementation of an in-house sampling plan or automation of the benefit adjudication process.

*The practices employed by the Company tend to cause an undesirable level of errors of omission, which appear to constitute unfair methods of competition, as defined in Chapter 176D of the General Laws. Specifically, Ch. 176D, section 3(1)(a) prohibits the misrepresentation of the benefits of any insurance policy. Unfair Claim Settlement Practices as defined in section 3(9) of that chapter include the following acts or omissions*

- (a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue ; and
- (b) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

#### (3) Price Waterhouse & Co. Report

A third portion of the American Family Market Conduct Examination is a study prepared by Price Waterhouse & Co. of Boston, Massachusetts. Price Waterhouse reported that the Company was generally cooperative and "imposed no restrictions" on their efforts.

The study makes these major points :

- Through July 1978, American Family had 2,621,259 cancer policies in force in the United States, some 9,053 of which were sold to Massachusetts residents. Although a small portion of the busi-

ness is sold to Massachusetts residents, there is a tremendous potential for sales growth in the State.

- Approximately 7.7% (1,010) of the policies held by Massachusetts residents consisted of several policy types that have not been approved by the Division of Insurance for use in the Commonwealth.
- The Company has not complied with a Massachusetts Regulation which requires insurance companies to maintain signed acknowledgements that each insured was provided with the appropriate disclosure notice at the time the policy is applied for. There is no evidence that the Company's agents have delivered the required disclosures forms to applicants.
- The company's brochures which also serve as policy applications use statistics from the American Cancer Society's pamphlet, "Cancer Facts and Figures". However, Price Waterhouse found several "potential misstatements" of the American Cancer Society figures in American Family brochures. For example :

The AFLA Brochure says :

88,000 women will develop breast cancer this year . . . Source: '76 Cancer Facts and Figures—American Cancer Society. 326,000 men will develop cancer this year . . . Source: '74 Cancer Facts and Figures—American Cancer Society. 326,000 women will die this year from breast cancer . . . Source: '74 Cancer Facts and Figures—American Cancer Society. 89,700 women will develop breast cancer this year.

Whereas the ACS Facts and Figures say :

The 1974 and the 1976 Cancer Facts and Figures state on pages 9 and 11, respectively, that the estimated number of cases are *estimates* and "are offered as a rough guide and should not be regarded as definitive." (Emphasis added.)

The 1974 Cancer Facts and Figures page 10, shows *estimated* new cases of breast cancer for both men and women at 89,700. For women alone, the estimate was 89,000. (Emphasis added.)

- Associate (agents) work under formal contracts with the Company which provide for commissions and other sales incentives only (non-salaried) ; they are not required to work full time for the company. Recruiting is primarily the responsibility of the state and district managers, who are also commission-compensated associates. The Company and the state manager have no character investigation reports on file for thirty-three of the fifty-nine active Massachusetts agents as of June 30, 1978 and personal history information could not be located for four of the active agents.

Amplifying this point, the report says :

A prospective agent recruited by a district manager must be approved by the regional and state managers. The approved application and related documents (background information, etc.) are forwarded to the home office by the state manager for review and approval by the regional

agency director. Under Company procedures at June 30, 1978, the agency director generally requested an Equifax (character investigation) after the approval process had been completed. If the results of this investigation proved to be unfavorable, the agent file would be returned to the agency director for consideration. Our work did not indicate that any Massachusetts applications had ever been rejected as a result of character investigations; however, as reflected in Exhibit B-III, over half of the contract files of active agents at June 30, 1978 did not contain background/character investigative reports. We also noted that four of the agents had not submitted any personal history information. Exhibits B-II and B-III show that even though a substantial number of Massachusetts agents have been recruited, most business is written by a few productive agents, and that 28 of the 37 agents terminated during the period January 1, 1977 through June 30, 1978 were terminated due to nonproductivity . . .

There is little if any, correspondence between the Company and its agents. Our review of the contract folders disclosed no correspondence and inquiries indicate that there are no general agent correspondence files maintained.

- Six Massachusetts policies were written by three unlicensed (at the time of policy issue) agents in 1977; the Company instituted new procedures in 1978 to prevent this problem from recurring.
- All marketing materials (primarily letters used within franchise groups) used in Massachusetts are not being submitted to the Company's home office for review, approval and control as required by Massachusetts regulations.

Significant shortcomings were found in the company's training methods. Supposedly, two days of training are being offered to agents trained in various State locations. A three day course is offered to selected individuals who are sent to the Company's home office in Columbus, Georgia. "There are no training materials provided by the home office to the new agent being trained in the field, and the home office does not receive any evidence of an agent's field training."

While the company does have a Training Handbook, it was not available in Massachusetts and "the Training Department does not keep organized attendance records." Price Waterhouse found the training records to be substantially incomplete. Materials not approved by the Company were used during the training sessions.

- Price Waterhouse also revealed that the Company spent a minuscule portion of its \$203 million revenues on training of personnel. American Family Life Assurance records disclose that during 1977 the Company spent only \$245,000 nationwide for training of agents, \$1,000 of which was spent in Massachusetts.
- In Massachusetts, the agents were using sample letters urging purchase of cancer insurance for distribution to officers and members of various groups. Says the report :

Copies of several letters used by companies and associations to recommend the cancer policy to employees/members were obtained during our visit for review by the engagement attorney of inclusiveness and representations as

coverage. Some of the letters indicate a 'group discount' and others indicate payment of a portion of the premium by the group employer. The letters had not been approved by the home office.

- To facilitate door-to-door sales, agents were encouraged to obtain voter registration "lists (which show name, age, occupation and street address) as a technique to identify senior citizens."
- In general, Price Waterhouse found few problems with policy applications:

The results of our statistic sample of policy applications indicated that Company procedures for issuing the policy types which were applied for by Massachusetts insureds during the period tested were at the proper application premium rates and payment modes.

However, potential problems were found with procedures which allow the agent to collect initial premiums from the insured and then remit funds with applications by agent's personal or agency check:

This procedure could result in an agent never remitting premiums (and related applications) to the Company's home office or kiting of premiums (which occurred in the instance of one state manager as documented in the Company's September 19, 1978 minutes of the Board of Directors).

- The Company does not segregate policyholder complaints from other correspondence. The only complaints that are logged are those which come from State Insurance Commissioners and State Attorneys General. There is no cross referencing between complaints and other correspondence on file in the claims department. No record of telephone complaints is kept. Nor are complaints maintained by policyholder's State or residence. Says the report:

Presently, there is no summary provided to upper management of complaints by type or resolution time by type of complaint. Meaningful monitoring of the average response time to inquiries and brief categorization by type of inquiry or complaint might indicate trends where actions, based on analyses of reasons for the inquiries, can be taken to reduce level of correspondence by eliminating the reasons which cause the inquiries.

As noted earlier in the report, many complaints never even reach the Company. In interviewing one American Family District Manager in Massachusetts, the Price Waterhouse team commented:

We noted one formal complaint against an agent by the Massachusetts office of the District Attorney, apparently never forwarded to the home office, dated January 6, 1977, which revealed that the Northampton Council of Aging had received a number of calls from elderly citizens stating that an agent had represented himself as being connected with or authorized by the Council on Aging, and also complained about a marketing brochure which states that the Company insures 'against' cancer.

- Price Waterhouse confirmed American Family's low loss ratio :

The rate of incurred claims to earned premiums for Massachusetts policies for the period January 1, 1977 through June 30, 1978 was approximately 42%.

However, the two most popular plans which account for more than 70 percent of cancer premium sales in Massachusetts showed an incurred loss ratio of 33.2 percent during this same period.

American Family offers the argument that as a block of cancer insurance business stays on the books and as policyholders get older, the ratio of incurred premiums to earned premiums goes up.

Using American Family's data, consulting actuary E. Paul Barnhart, acting in the Company's behalf, calculated an anticipated loss ratio of 56.09 percent for the Company's cancer policies over 30 years. In short, by this estimate, American Family's cancer insurance plans will pay benefits of only 56 cents on each premium dollar collected from policyholders over 30 years. Moreover, as insurance experts point out, loss ratios ignore investment income. Large active life reserves are maintained during the early years that a policy is in force which are gradually returned to the claimant in later years. Interest on these reserves is really interest on the policyholders premium dollar. Thus, interest income must be added to premiums in loss ratio calculations in order to obtain a true benefit-to-premium ratio.

Lindalee Lawrence, then of the Massachusetts Insurance Department, recently said in her May 24, 1979 testimony before a State agency :

We have calculated such loss ratios for American Family using the data underlying the 56 percent estimate and the reasonable assumption that the company can earn 6 percent on its investments. The adjusted loss ratio is 49 percent. . . . Returning benefits of only 49 cents per premium dollar to all consumers over 30 years of a policy's life time, cancer insurance is clearly no bargain.

Attorney Baldwin noted *it was the Company's policy to increase rates when loss ratios went over 50 percent.* Moreover, as Price Waterhouse reports, the Company is instituting rate increases for older policies which have been in effect for some time which will have the effect of lowering long-term loss ratios :

- American Family says that its goal is to eventually pay at least 50 percent of the charges incurred by policyholders who have cancer. American Family calculated that it *presently pays on the average 37 percent of all submitted charges* but Price Waterhouse concluded these figures were "unreliable." *Price Waterhouse found that American Family was paying an average of only 23.4 percent of the charges submitted to it by its policyholders.*
- *Price Waterhouse found that there were significant errors in the determination and payment of claims.* In 20.8 percent of the cases in their sample, benefits were not determined in accordance with policy terms and in 11.2 percent of the cases, explanation of benefit letters

were incomplete as to the additional benefits which would be available to the insured upon the submission of additional documents. In addition, "Complaints from 13 policyholders involving twenty separate claim matters resulted in additional payments by the Company to the insured in six instances." Six errors out of 20 claims reveals *an error rate of 30 percent*.

- Price Waterhouse confirmed the extent to which cancer insurance sales are geared to senior citizens. *The mean policyholder age at the application date from their sample was found to be 56 years. The mean age at the date of filing a claim was 66.2 years of age.* Some 55 percent of their sample had Medicare and Blue Cross/Blue Shield Medicare supplement insurance. Another 33 percent had major medical coverage with Blue Cross/Blue Shield. What this suggests is that 88 percent of cancer insurance policyholders would have major problems with coordination of benefits. While this finding bolsters that of RL Associates (above) it might be stated that the Company's figures show that 28 percent of all policyholders are over 55 and 11.5 percent are over age 65.

## MARKET CONDUCT EXAMINATION: AMERICAN INCOME LIFE INSURANCE COMPANY

In October and November 1978, the Massachusetts Department of Insurance conducted an examination of the cancer policies sold in that State by American Income Life Insurance Company. The Department enlisted the assistance of the respected accounting firm, Coopers and Lybrand as well as insurance expert and attorney Paul G. Gitlin. The study revealed a significant number of violations of law and regulations. Among these findings were the following:

- The Company "does not have any system to insure that policyholder complaints are resolved satisfactorily and on a timely basis."
- There was evidence that some policyholders coverage per the application "was reduced prior to the policy issuance to correspond with the Company's stated premium amount without the consent of the policyholder."
- The Company's lack of underwriting could "purport coverage to a policyholder which will not exist at the time a claim is filed. The only underwriting consists of asking if the individual has ever had cancer." The report recommended that the Company review medical records prior to the approval of the applications.
- The percent of each premium dollar returned to the policyholders in the form of claims is low. Comparing the premiums written to the losses paid "for the most recent thirty-three month period developed a ratio of 25.17. It would appear that the paid loss ratio would approximate the incurred loss ratio over such a period," said the report. This means that roughly 75 cents on each dollar paid in for the purchase of cancer insurance policies are retained by the company in profits, commissions paid to agents or administrative expense. The national average among all companies selling health insurance is to keep only 20 cents on the premium dollar for profit, commissions and administrative expenses and return 80 cents to the policyholders in claims.
- The Department found serious problems with the applications forms used by the Company. "While the agents are directed to fill in the information obtained, the form is drafted as though the consumer is responsible for filling it in." This is carried to the extreme in the sentence immediately preceding signature in which it is spelled out that the signature is a representation that all the information on the form is true and correct. Thus the consumer will bear the burden of any mistakes or omissions in the form filled out by the agent.

In addition to the above problem, the application forms (Nos. CAN and CDV) exclude certain information required by Massachusetts insurance regulation:

(1) Although the benefits recoverable represent less than 50% of the cost of an average hospital stay, the application does not contain the required statement that "this policy is supplemental in its coverage and is meant to be purchased in addition to basic health insurance. This policy pays for—% of the cost of an average stay in a Massachusetts Hospital as defined by the Massachusetts Division of Insurance Hospital Cost Standard."

(2) The application fails to clearly and unambiguously disclose the company's pre-existing condition exclusion provision.

(3) The application fails to contain most of the additional information required by Massachusetts Insurance Division regulation. In addition to its failure to include the information described above in this report, the company fails to disclose: the existence and extent of the waiting period; the fact that the reception of some benefits are contingent on hospitalization; and the terms of renewability and premium guarantee. There is also no room provided on the application for the applicant's signature specifically indicating that he/she understands the required disclosures.

(4) The application provided does not contain questions that elicit whether the insurance sought by the company replaces other accident and sickness insurance. Massachusetts Insurance Division regulations require that a specific disclosure must be made if a consumer is replacing present coverage by purchasing a new policy. To effectuate this disclosure, the regulation also requires that any application ask questions designed to elicit this information.

Problems were also found with application form No. CDK—another cancer insurance policy sold in the State. Among these, said the study, was the fact that "the company has reserved the right to increase premiums on all policies sold within the State." The reservation of the right to increase premiums of a specified disease policy is an apparent violation of two Massachusetts insurance regulations, said the report.

Perhaps the major finding of the study was that "the marketing materials used by this company appear to violate numerous Massachusetts statutes" as detailed below. "One major cancer policy numbered CDK is marketed by direct contact with Union Governing bodies. The policy numbered CAN is marketed by agents using a prepared statement and associated visuals with individual consumers. The leads for this sales presentation are obtained by using a letter prepared by the company agents and mailed on union or credit union stationery."

Violation of the Massachusetts General Laws include:

(1) *The marketing materials do not contain information concerning the average financial cost of the treatment of cancer. Because of the extensive fear of getting this disease, many people tend to overestimate the total cost of treatment and to be unable to determine the extent to which these costs relate to medical care*

as compared to the associated non-medical costs. Without such data, it is difficult to determine if the policy benefits available are worth the premiums charged.

(2) *The marketing materials refer to an aggregate benefit obtainable under the CAN policy.* This amount is overstated by ten percent, because the materials include reference to a policy provision which provides a ten percent additional benefit which has not been approved in Massachusetts.

(3) *The policy is marketed by emphasizing the aggregate benefits available.* This sum is used as a focal point for the visual part of the presentation and is repeatedly referenced in the verbal part of the presentation.

While the agent making the presentation is told to say that this aggregate sum will not be paid in every case, he/she does not inform the potential policyholder of the substantial improbability that claims will approach this amount. The policy provides an aggregate benefit of \$32,400.00. The average policy claim for the period January 1, 1977 through June 30, 1978 was \$1,396.15. Accordingly, to receive the full aggregate benefit, the average policyholder would require twenty-three distinctive claim opportunities.

*The marketing method emphasizing an aggregate benefit which is unlikely to be paid by the company has the capacity of deceiving consumers concerning the potential benefits of obtaining this policy, and therefore, appears to violate Massachusetts General Law.*

(4) *The agent is instructed to read a letter at the beginning of the presentation which states that one of the two most crippling expenses a family can incur is cancer (the other being death).* Massachusetts data indicates that the most prevalent and most costly disease afflicting this state's population is not cancer but rather, heart disease.

The *misrepresentation* of the relative expense of cancer appears to violate Massachusetts General Law.

(5) *The verbal presentation contains a reference to the usual cost of cancer treatment in the range of \$30,000 to \$40,000.* Available statistics indicate the total cost of cancer is below \$20,000. Much of this cost is not treatment related, but rather includes the costs associated with child care, and other factors. This clarifying information is not disclosed, nor is the fact that the policy offered is not designed to indemnify a consumer for these subsidiary costs.

*The use of information which is not sufficiently clear and complete to avoid confusion, and the failure to disclose additional relevant information appears to violate Massachusetts General Law.*

(6) *The prospect is told that a decision must be made at the completion of the presentation because the agent cannot come back into the home.* The examination team observed at a company sales meeting that agents were instructed to make repeat calls when necessary.

The *misrepresentation* of the agent's availability for repeat visits and the effect of this statement appear to violate Massachusetts General Law .

(7) *The marketing method is designed to create or enhance the consumer's fear of contracting cancer.* The visuals include a page of names, printed on a black background, of famous individuals who have died of cancer, and a corresponding page on which the following words appear: 'CANCER CAN HAPPEN TO YOU.' The associated verbal presentation recites statistics concerning the number of Americans who have or will get cancer.

The inclusion of this otherwise superfluous information creates or enhances an emotional atmosphere of concern about contracting cancer. Insurance purchases should be contemplated and made for functional reasons, and not as a result of an artificially created fear of being afflicted with a particular malady. The infusion of this information has the effect of concentrating the consumer's attention on the disease itself, and away from the costs and possible benefits of the policy. This may trigger purely emotional responses to the purchaser's innate fear of cancer, and may result in a decision to purchase based-on irrational reasons.

*Inducing the purchase of insurance for emotional rather than functional reasons* appears to violate Massachusetts General Law.

(8) *The marketing methods used misrepresent the effect of other insurance policies on the consumer's retention of benefits provided by stressing that the cancer coverage will pay expense benefits regardless of the existence of other insurance.* While that representation is technically true, it is nevertheless misleading because it fails to inform the consumer that there exists a possibility in Massachusetts that the benefits provided by this policy will reduce any benefits expected from the consumer's other insurance policies, such as, Blue Cross and Blue Shield.

The *misrepresentation of the possible effect of overlapping insurance coverage* appears to violate Massachusetts General Law . . . because it has the tendency to mislead the public about the extent of insurance proceeds that may be paid. The effect of other insurance companies' coordination of benefit provisions should be clearly disclosed.

(9) *The agent is instructed to inform the prospect that payment will be made on a claim for cancer that is diagnosed by a physician any time after a one hundred and twenty (120) day waiting period.* This is claimed to be true 'even if the doctor says that that tumor has been growing there for 4-5 years.' Since the policy's pre-existing condition clause requires a positive pathological determination of cancer, this statement appears to be correct. But the policy also contains a limit on payments for undiagnosed conditions to those medical costs incurred within ten (10) days preceding the date of diagnosis. This limitation is not disclosed in the marketing materials. Therefore, the above quoted statement may deceive a consumer as to the benefits obtainable.

The *non-disclosure and resulting misrepresentation* appear to violate Massachusetts General Law.

(10) *The marketing materials fail to disclose the extent to which the policy meets the costs of a short, average and long hospital stay as defined in the 'Massachusetts Division of Insurance Hospital Cost Standards.'*

The company's failure to provide the required information appears to violate Massachusetts General Law.

(11) *The policy is guaranteed renewable, but the company has reserved the right to increase the premiums uniformly on all policies in force in Massachusetts.* The fact that premiums may be adjusted at the company's option without specific Division approval is not conspicuously disclosed in any of the marketing materials.

The failure to conspicuously disclose the potential for premium increases without Division approval appears to violate Massachusetts General Law.

(12) *The visual portion of the presentation contains a statement in bold face that (the policy) "pays for preexisting cancer after 120 days."* This statement is followed in smaller print by the explanatory phrase that this is true provided that cancer has not been diagnosed prior to the expiration of this time period. This printing layout emphasizes the first statement and deemphasizes the second with the possible effect that the consumer will misconstrue the pre-existing condition exclusion.

The practice of emphasizing, in positive terms, half of the company's pre-existing exclusion appears to violate Massachusetts General law.

The Massachusetts Department of Insurance also contracted with RL Associates asking them to interview a sample of those who had recently purchased cancer insurance policies from American Income. They concluded as follows:

- American Income sells cancer policies primarily to working aged people using an implied union endorsement . . . Almost all policies are sold by agents rather than through the mail. Overall, the company trades on an implied endorsement by the potential policyholders' union, but this appears reasonable in light of the union's general cooperation in providing lists of names.

About one-fifth of the respondents first heard of the policy through their union . . .

Presumably as a result, three out of four of those with an opinion think the policy is endorsed by their union.

- *Only one in five said the agent pressured them to buy the policy the same evening, but six out of seven actually did buy their policy at that time.* Thus, the apparent sales pattern is for the agent to get into the home, often through a union recommendation, spend a reasonable length of time, sell the policy, and then get out without ever coming back again.
- *The respondents in this sample say they bought a cancer policy because of fear of the disease itself or of its costs and because of the widespread incidence of the disease.*

At least some of the information about incidence and cost had come from the agent. Three fourths of cancer policyholders said that the agent had mentioned that "1 out of 4 Americans will eventually get cancer." Of those who recalled what the agent said about the cost of cancer, almost 80% said that the agent had mentioned a cost range of \$30,000-\$40,000.

- *While respondents are very concerned about the incidence and cost of cancer, they are not knowledgeable about the potential benefits of the policy.* For instance, only one in four "knew" that there was a 60 day waiting period before the policy becomes effective.

More important, most respondents did not know the amount of benefits typically paid by the policy. Respondents were asked what part of a \$20,000 and of a \$2,000 bill for cancer would be paid by their policy. In both cases, most people did not even think they knew, and of those that did "know," the great majority thought the policy paid the total amounts. Similarly, almost no one knew what coordination of benefits meant, and as indicated above, most people did not understand the concept as it applies to Blue Cross policies.

RL Associates summarized their findings :

**Policyholders are not particularly well informed as to the benefits of the policies, and, in many cases have overlapping coverage of several kinds.**

**American Income's agents are clearly more interested in presenting the horrors and catastrophic costs, real or imagined, of cancer than they are in describing the likely real benefits of the policies they sell.**

The Company was given 60 days to correct these violations and submit new promotional information.<sup>1</sup>

<sup>1</sup> In its February 28, 1979, response to the Department, American Income responded that it had made a number of corrections in the policies, advertising material, and training manual used by its agents. They notified the Commissioner that they were withdrawing their insurance form CDK and that this policy would no longer be sold in Massachusetts. American Income made numerous other corrections saying, "we trust you will find this material in order and that it meets the objections set forth in the report."

MARKET CONDUCT EXAMINATION: UNION FIDELITY  
INSURANCE COMPANY<sup>1</sup>

In December of 1978, the Massachusetts Department of Insurance released a market conduct examination of Union Fidelity Insurance Company with particular reference to its cancer and medicare supplementary policies. Their examination is made up of three parts: auditing work by Touche Ross and Company, market research activities by RL Associates, and Boston Attorney Arthur J. McCabe II was asked to examine legal issues. The Massachusetts study is summarized below:

*(1) Violations of Law and Regulations: Arthur McCabe, Esq.*

In a December 14, 1978 letter to the Insurance Department, Attorney Arthur McCabe summarized the principles of law and regulation applicable to insurance sales, advertising and promotional material providing background for his work:

In summary, advertising capable of being interpreted in a misleading way should be construed against the advertiser. One should look not only to the literal meaning of the words used, but also to all that is reasonably implied. The team in this examination has employed its expertise to evaluate an advertisement as it would appear to the general public, which includes many persons who are of limited experience, education or training and who are not conversant with health and insurance needs and resources. It is a fact of the marketplace that many who make purchases do not or cannot stop to analyze fully the advertising claims. All too often decisions are governed by appearances. Advertising practices may violate Commonwealth regulations not only where there is proof of actual deception, but also where representations have a capacity or tendency to deceive. Many times advertising innuendo induces misunderstanding or deception as surely as outright false statements.

In order to evaluate the completeness and fairness of advertising and promotional materials, it is necessary to know all that is relevant to the subject matter of the advertising, including much information which is omitted from the actual advertisements. To accomplish the evaluation, it was necessary to acquire and analyze extensive information concerning the costs of medical treatment, the courses of treatment and the development of various diseases and health care resources available to the general public. This is a task which is virtually impossible for the overwhelming majority of the general public. The enormity of the task underscores the need for full

---

<sup>1</sup> It should be noted that early in 1978 the company was purchased by the well respected corporation, Filmways, Inc., and has initiated significant reforms.

and fair disclosure in company advertising. It is apparent that between the company and the consumer, only the company has the realistic opportunity and the economic and reference resources available to perform such a task.

Attorney McCabe analyzed Union Fidelity's Cancer Famous People Advertising brochure and found 90 apparent violations of statutes and laws. He examined the Cancer Benefit Policy and riders and found 20 apparent violations. Finally, he analyzed the Cancer Extras Rider and Cancer Increase Rider and found "in excess of 120 apparent violations of Massachusetts law."

McCabe comments:

The apparent violations are representative, and not exhaustive of violations related to the cancer benefit policy. In summary, the brochures failed to include sufficient material and relevant information to permit the consumer to make a meaningful and informed decision concerning the adequacy and appropriateness of the insurance policy promoted. The information omitted includes, but is not limited to, average individual costs of cancer treatment, courses of treatment of cancer, company loss ratios (benefits paid/premiums received) and relationship to other insurance available to the consumer. As a result, the reviewed advertising was not sufficiently clear and complete to avoid deception or the capacity or tendency to mislead or deceive the consumer. The brochures reviewed contain numerous half-truths or ambiguous statements which contribute to the capacity or tendency of the materials to mislead or deceive. In some cases, because of the time limit and the benefit structure of the policy, it is literally impossible for the policy holder to collect benefits as advertised. In other cases, because of the usual course of cancer treatment and general hospital practices, it is highly improbable, but not literally impossible, that full benefits will be paid. In any case, the sale of the subject policies is unconscionable when viewed by accepted legal standards.

In the interest of space, only the portions of McCabe's analysis which relate to the Famous People Advertising brochure are summarized below. The following is an analysis of benefits payable under this policy:

SUMMARY OF POLICY BENEFITS AS QUOTED FROM McCABE'S REPORT

Maximum Benefits Payable: \$150,000 Premium for Individual Plan:	
Per month.....	\$4. 40
Per year.....	52. 80

*In-Hospital Benefits*

Hospital Confinement (must be overnight resident in qualified hospital) (periods separated by less than 30 days are considered one confinement period):	
90/day—1-7 days.....	\$630
60/day—8-90 days.....	4, 980
Total available.....	5, 610

**Physician :**

Actual charges up to \$15 per day. Physician cannot be surgeon who performs surgical procedures :

\$15/day to a maximum of \$900----- \$900

**Nursing :**

Must receive full-time and private care and attendance other than that regularly furnished by the hospital and only when authorized and requested by a legally qualified physician and surgeon. Actual charges up to \$36 per day :

\$36/day to a maximum of \$900----- \$900

**Drugs and Medicines, including Chemotherapy :**

10% of hospital confinement charges to \$375. The policy makes no mention of chemotherapy. The policy pays actual charges only if they are less than 10% of hospital confinement. To collect maximum drug benefits one must be a resident in a hospital for 59 consecutive days. Furthermore, chemotherapy, if it is covered under this section, usually is taken on an out-patient basis at hospitals ; thus, it would not be covered in any case.

*In and Out of Hospital Benefits Maximum Available***Surgical Benefits :**

\$45-750 per operation. Out of the 40 surgical procedures listed in the policy, only four procedures provide the full \$750. The average is less than \$450. Multiple surgical procedures through the same incision are treated as one procedure. Although there is technically no limit on the number of operations, sound medical practice would place a physical limit on the number of operations a patient could undergo during a 3-year period----- \$750

**Anesthesia :**

The policy will pay actual charges up to \$105 for an anesthesiologist as long as the anesthesiologist is not regularly employed by the hospital. Most hospitals have at least one on staff-----

\$105

**Blood and Plasma :**

The policy will pay actual charges up to \$450, but it excludes credits for replacement blood donated on behalf of the recipient-----

\$450

**X-Ray—Radiation—Cobalt Therapy :**

The policy will pay actual charges up to \$1,500, but it will not cover diagnostic X-ray or other diagnostic procedures or laboratory tests related to these treatments, nor does any other provision of the policy cover these-----

\$1,500

**Ambulance :**

The policy will pay actual charges up to \$75 for each confinement period (2 visits separated by less than 30 days are treated as one) for ambulance trips to and from the hospital if the patient stays overnight at a qualified hospital. To collect maximum benefits a policyholder must be confined 10 times during a 3-year period, with each confinement being separated by more than 30 days-----

\$750

Maximum total regular benefits----- \$11,340

Remaining Benefits to be collected under Extended Hospital

Benefits Charges----- \$138,660

**Extended hospital benefits**

Cancer diagnosed during the first 120 days during which the policy is in effect is not covered for two years. The policy will pay 100% of usual and customary charges up to \$250/day for Hospital Confinement and drugs and medicine benefits. To collect, assuming the usual and customary charges are \$250 or more, the patient must be confined 555 days consecutively.

The total number of days covered is 3 years from the date of diagnosis, minus 90 days covered under regular benefits, or 1005 days.

If the usual and customary charges are less than \$137.97 per day, it is literally impossible to collect maximum benefits.

**A. VIOLATIONS WITH RESPECT TO FORM AND CONTENT OF ADVERTISEMENTS**

McCabe quotes the Massachusetts General Laws, ch. 175, section 109 and Regulation 1-74, sections 5(a) and 5(b) as follows:

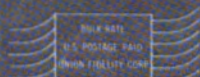
**Section 5. Form and Content of Advertisements**

A. The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

B. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

McCabe then cites the apparent violations of law, each keyed to pages in the advertisement, which follows.

UNION FIDELITY LIFE INSURANCE CO.  
UNION FIDELITY OFFICE PARK • TREVOSE, PENNSYLVANIA 15047



John Doe  
123 Main St.  
Anywhere, U.S.A.

WHATEVER  
HAPPENED TO  
THESE  
FAMOUS  
PEOPLE



ZIP OPEN HERE



# ELIGIBILITY

To Apply  
Is Now Available To

S. Sandol

in ELIGIBILITY NO: 5059802

## The Union Fidelity \$150,000.00 CANCER PLAN

Provides benefits for Cancer treatment in addition  
to any Group Insurance Plan or Medicare —  
benefits are payable in cash direct to:

S. Sandol

or anyone designated by the insured

Coverage under this plan is guaranteed to you  
and members of your family who have not had Cancer.  
Details of the Plan are given inside.

Henry J. [Signature]  
Chairman of the Board

**APPLY BY**  
February 15, 1979  
and get FREE . . .  
**YOUR CANCER  
FACT PACK**



DETACH ALONG BROKEN LINE

**ACT NOW!**  
**SEND NO MONEY**

**HERE'S HOW  
TO APPLY**

1. Choose the benefit amount best for you. Check if you want the Individual or Family Plan.
2. Complete the application. Be sure to list family members to be covered.
3. Sign at bottom and mail today in enclosed postage paid envelope. Send no money, you don't risk a penny. You'll receive your Policy by return mail to examine. Pay nothing unless you're satisfied.

**WE'VE ALL BEEN  
GIVEN FAIR WARNING**



TV reports, radio programs and newspapers tell us of the perils of cancer every day. You can't be insured once cancer strikes . . . \$1.00 a month will cover you or \$6.00 a month covers you and your entire family . . . it's a decision that shouldn't wait one day longer.

Application Form Eligibility No: 5059802

CHECK AMOUNT AND PLAN DESIRED	AMOUNT		PLAN	
	<input type="checkbox"/> \$150,000	<input type="checkbox"/> \$100,000	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> FULL FAMILY
1-5840 (Please Print)	APPLICATION FOR: UNION FIDELITY LIFE INSURANCE COMPANY 153387-5 TREVOSE, PENNSYLVANIA			
NAME	S. Sandol		[Redacted]	
ADDRESS	[Redacted]			
CITY	[Redacted]	STATE	[Redacted]	ZIP
DATE OF BIRTH	DAY	MONTH	YEAR	AGE Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
List all dependents to be covered under this Plan. DO NOT include name that appears above. Use separate sheet if necessary.				
NAME (PLEASE PRINT)	RELATIONSHIP	SEX	DATE OF BIRTH	AGE
1				
2				
<input type="checkbox"/> Check here if you want Coverage for your Children. <b>REPRESENTATION &amp; AGREEMENT OF POLYHOLDER:</b> I hereby represent that to the best of my knowledge, information and belief, no person to be insured under this policy has now or has ever had cancer in any form, except who is to be excluded from the coverage of the policy.				
SIGNATURE		DATE		
[Redacted]		[Redacted]		

Entered in this space all necessary information for processing by the carrier.



## UNION FIDELITY LIFE INSURANCE CO.

UNION FIDELITY OFFICE PARK • TREVOSE, PENNSYLVANIA 17047

Miss S. Sandol

Dear Miss Sandol:

It was CANCER ... that's the sad truth about what happened to each and every one of the famous people you see here. But the saddest fact of all is ...

... for every celebrity struck by Cancer, there are countless other Americans who are also being struck - ordinary folks like you and me. According to the American Cancer Society, Cancer will strike 55 million Americans now living ... 172,500 in D.C. alone ... that's 1 out of every 8 people, with a victim in 2 out of every 3 families.

How many families would you guess live on your street?

40 families? 50? 75? If there are 75 families, 50 of you will have Cancer touch your lives. The American Cancer Society record shows that Cancer is as dreadfully close to you as that.

We CANNOT promise to prevent Cancer from striking you, or to cure it. But we can guarantee you financial protection of up to \$150,000.00 to help you beat the disease ... to give you the best possible fighting chance.

Cancer can be cured. But specialized Cancer treatment can be extremely costly. Last year, Miss Sandol, Cancer cost the American people \$1 billion, according to the American Cancer Society. The late Senator Hubert H. Humphrey, himself a Cancer victim, warned that "Only a few millionaires can afford Cancer." That's exactly why we're offering you the opportunity to be protected by the \$PL \$150,000.00 CANCER BENEFIT PLAN.

The Plan will pay you cash for Cancer treatment both in and out of the hospital. And every penny of the money is paid DIRECT TO YOU or anyone you choose in addition to Group Insurance, Medicare or any other Plan.

The rest of the facts about the Cancer Plan are inside. Your application -- in the name of "S. Sandol" -- is on the back. The cost is reasonable ... as little as \$3.25 a month. I urge you to apply for this additional protection now. If you apply by Feb. 15, 1979 you will receive a special Bonus -- your Cancer Fact Pack -- absolutely FREE. Call now. Elsewhere, once Cancer strikes, you can't buy this protection at any price.

Sincerely,

*John H. Cooney*  
John H. Cooney  
President

P.S. If you have any doubts about the real need for Cancer Insurance Protection, Miss Sandol, read the enclosed newspaper statement from the late Senator Hubert H. Humphrey. He said it all.



The Same Thing  
That Happened  
To These  
Famous People...  
Could Happen  
To You!

### Premium Refund Authorization

ELIGIBILITY NO. 5059802 FOR S. Sandol

When you receive your policy, we encourage you to examine it as carefully as you like. Remember, if made within 10 days of issue, you may return the policy for a full refund of your premium. If you're not satisfied, if you are unhappy for any reason after you've paid your premium, you will get your money back. Just return the policy within 10 days of receipt, and a refund check will be sent to you immediately ... no questions asked. There's no risk to you now when you apply ... and cancel even after you've paid your first premium.

UNION FIDELITY LIFE INSURANCE COMPANY, HOME OFFICE, TREVOSE, PA.

# CANCER...

## WILL STRIKE

- 55 million Americans alive today
- 1 out of every 4 people
- 2 of every 3 families
- 700,000 new cases in 1978
- One case every 45 seconds

## CANCER CAN BE CURED

- Almost 2 million Americans alive today have been cured
- 233,000 more will be cured this year 1/3 of all new Cancer Cases
- 117,000 more could be saved this year with earlier treatment

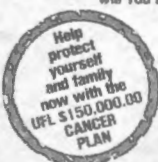
## CANCER TREATMENT CAN BE EXPENSIVE

- Cancer costs the American People \$3 Billion a year
- Average Cancer hospital stay is twice as long as other hospitalization
- Cancer costs include higher fees for physicians' services, drugs, nursing care and sick-room equipment

## ESTIMATED CANCER CASES BY STATE



How Many Victims Will There Be in Your State? Will You Be One Of Them?



Statistics from the American Hospital Association and the American Cancer Society. Your state's Cancer estimate is based on the American Cancer Society's prediction that 25% of all Americans will get cancer.

## PAYS YOU UP TO \$150,000.00 CASH BENEFITS!

### PLEDGES TO OUR POLICYHOLDERS FROM HARRY T. DOZOR, CHAIRMAN OF THE BOARD

**CASH PAID FOR ALL FORMS OF CANCER**  
You collect full benefits for all forms of Cancer. There are no costly deductibles or co-payments.

**PAYS CASH IN AND OUT OF THE HOSPITAL**  
Your Cancer Plan pays you cash benefits for care and treatment both in and out of the hospital.

**ALL BENEFITS PAID IN CASH DIRECT TO YOU**  
All claims checks are sent directly to you or anyone you choose. Use the money as you see necessary... for doctors' bills, hospital, therapy, nursing or convalescence.

**CASH PAID IN ADDITION TO ANY OTHER PLAN, EVEN GROUP OR MEDICARE**  
Benefits are paid in addition to any other coverage you may have, even Medicare. With Cancer costs so high the additional cash you get from this plan could help you avoid financial troubles, debts and money worries.

**GUARANTEED ACCEPTANCE IF YOU'VE NEVER HAD CANCER**  
We guarantee you will be accepted if you've never had Cancer.

**MONEY-BACK ASSURANCE**  
Send no money now. We guarantee to issue your in-force policy for you to examine for 21 days. Read it. Show it to your friends, make sure it's everything we've said it is. Then when you're satisfied, send your first premium. Of course, if you don't, you will have no coverage. Even after you've paid your first premium, if you decide you don't want coverage, return your policy within 30 days and your money will be promptly refunded — we guarantee it — this is a no-risk offer!

*"I thank the Lady for writing to people about the wonderful service your Company has given me. It was a God's blessing that I took the insurance and I'm back at chemotherapy again. It probably took more bills to send you. I've received your second check and thank you from the bottom of my heart. These medical bills are coming fast."*

Mrs. C. Kelly E. Palestine, Oh.

**GUARANTEED RENEWABILITY**  
Your Cancer Plan is guaranteed renewable for life regardless of physical condition until maximum benefits have been paid. Premium rates are guaranteed not to be increased individually... but only if changed on all policies of this form number series 21 50 in your state.

**ONE RATE, SAME BENEFITS FOR ALL AGES**  
Whatever your age, even if you're 65 or over, you will receive the same benefits, at the same rates as younger folks. We guarantee it!

**FULL BENEFITS OVER 65**  
**EXCEPTIONS AND LIMITATIONS**  
Cancer Policy basic and extended hospital benefits shall not exceed a total maximum of \$150,000, and will not be paid beyond 3 years of date of diagnosis for each covered person (not applicable in Ala. and S. Dak.). Coverage will terminate on any insured person when maximum benefits have been paid. Loss resulting from cancer first diagnosed by a qualified pathologist before the effective date of the policy is not covered; nor is confinement in any institution where you're not required to pay in the absence of insurance (except Mo.); or any U.S. Government hospital for the treatment of members or ex-members of the armed forces, including V.A. hospitals (except Mo.); nursing or rest homes or extended care facilities.

Cancer first diagnosed during the first 120 days the policy is in force is not covered for two years. (Mt. and Wash. 1 year; 6 mos. Nev.).

**BEST POLICYHOLDER SERVICE AVAILABLE**  
Our specialists are trained to get the information you request, fast and courteously. We'll supply you with a Toll-Free Hotline number to our Policyowner Service Department, where you can get an answer to any question.

### SPECIAL FREE BONUS WHEN YOU MAIL BY THE DEADLINE DATE

Get your personal copy of the exclusive Cancer Fact Pack, the Frank report of Cancer's warning signs, plus How To Cope Should Cancer Strike. The kit is yours FREE... when you apply or mail your request by the deadline date.

**\$150,000.00 CANCER BENEFITS SUMMARY**

**All Cancer Benefits Are Paid In Cash Direct To You, Or Anyone You Choose, In Addition To Medicare, Group Or Any Other Plan.**

**IN-HOSPITAL BENEFITS**

**HOSPITAL CONFINEMENT:**  
\$90.00 Per Day . . . for the first 7 consecutive days . . . \$60.00 Per Day thereafter. (After 90 consecutive days of hospitalization, see Extended Hospital Benefits.)

**PHYSICIAN:**  
Up To \$15.00 Per Day . . . Maximum of \$300.00 for care by a physician or surgeon, other than surgeon performing surgery.

**NURSING:**  
Up to \$36.00 Per Day . . . Maximum of \$900.00 for private care by a Registered Nurse or Licensed Practical Nurse.

**DRUGS AND MEDICINES, INCLUDING CHEMOTHERAPY:**  
10% Off Hospital Confinement Benefits . . . Up To \$375.00 for actual charges incurred for drugs and medicines.

**ADDITIONAL BENEFITS**

**EXTENDED HOSPITAL BENEFITS:**  
Up To \$7,500.00 A Month . . . \$250.00 A Day . . . Cancer Policy benefits increase after you've been hospitalized past 90 days. Even though your basic benefits are exhausted, you needn't worry. This is when you'll be paid 100% of all hospital charges, up to \$7,500.00 a month (\$250.00 a day). These are in addition to benefits you've already received. Benefits will be paid continuously until you're discharged from the hospital . . . or until you've collected a lifetime maximum of \$150,000.00.

**IN-AND-OUT OF HOSPITAL BENEFITS**

**SURGICAL:**  
\$45.00 To \$750.00 Per Operation . . . no limit on number, according to policy surgical schedule.

**ANESTHESIA:**  
Up To \$105.00 . . . for each internal operation; \$45 for skin Cancer operation. No limit on number of operations . . . in or out of the hospital.

**BLOOD AND PLASMA:**  
Up To \$450.00 . . . for charges incurred for blood and plasma . . . even as an outpatient. No maximum on benefits for leukemia.

**X-RAY-RADIUM-COBALT THERAPY:**  
Up To \$1500.00 . . . for X-ray, radium or cobalt treatment . . . even as an outpatient.

**AMBULANCE:**  
Up To \$750.00 . . . for transportation to and from a hospital, limited to \$75.00 for each confinement period.

**SPECIAL FREE BONUS . . .****CANCER FACT PACK**

A Frank Report on Cancer's Warning Signs, Plus Life-saving Facts And Information And How To Cope Should Cancer Strike. It's yours absolutely FREE . . . when you apply or mail your request by the deadline date printed on the Eligibility Certificate.



**AN OPTIONAL \$100,000 PLAN IS ALSO AVAILABLE . . . AT REDUCED RATES, WITH BENEFITS 2/3 OF THE \$150,000 PLAN ABOVE**



Harry T. Dazor  
Chairman of the Board  
Union Fidelity Life Insurance Company

Cancer is so horrible and dreaded a disease that the normal reaction is to say "It can't happen to me." That's how I used to deal with the threat of Cancer. But it's the worst possible thing a person can do. Unless you are willing to face the hard facts of the disease, you can't protect yourself physically or financially. Read the letter below from one of our Policyowners. It's sad, but it may keep you from the mistake of waiting too long to get protection.

"My husband has Cancer. When I received your application it made me very upset. I asked my husband: 'It's a little late for this, isn't it?' I put the application in the trash.

Yes, we have been struck by this horrible disease. My husband does not have much time left.

When I went to bed last night I thought and thought about the application. Then it came to me that the application was still good for my children and for me. I got right up and got it out of the trash.

I am so sorry that I hadn't seen or heard of my Cancer Policy before. I really can't say that if I had I would of taken the protection. People say . . . "It can happen to others, but not me."

"Now we have been struck with this horrible disease, and it has crippled us financially. The expenses are impossible to meet. It puts you so far in debt you can't even look ahead. We know!

I would like to thank you for sending me your application. I hope with all my heart we will never need it but, as I know, it is a threatening disease. It can hit anyone, anytime."

Beverly L. Rayburn, Sandy, Utah

**APPLY BY THE DEADLINE DATE**  
and get FREE . . .  
**YOUR CANCER FACT PACK**

**SEND NO MONEY NOW**

- NO AGE LIMIT.
- GUARANTEED ACCEPTANCE AS LONG AS YOU'VE NEVER HAD CANCER.
- ONE RATE FOR ALL AGES.
- FULL BENEFITS FOR FOLKS OVER 65.
- CASH BENEFITS PAID DIRECT TO YOU OR ANYONE YOU CHOOSE.
- TWO PLANS TO CHOOSE FROM.

**\$150,000.00 PLAN**

INDIVIDUAL	FULL FAMILY
\$4.40 a month	\$6.90 a month

**\$100,000.00 PLAN**

INDIVIDUAL	FULL FAMILY
\$3.25 a month	\$4.90 a month

**NOTE TO FOLKS 65 AND OVER:**  
Benefits are paid to you in addition to any benefits you may get from Medicare.

**ALL-FAMILY PLAN:** Includes newly insured spouse and all unmarried dependent children to age 21 . . . all of a full-time student. When children are excluded, all future children will be automatically covered at birth at no additional premium.

**ACT TODAY . . .**  
**SEND NO MONEY**

Fill out the application on the back page and mail today.

**THE UFL CANCER POLICY COVERS CANCER, HODGKINS DISEASE AND LEUKEMIA ONLY.**

## Few Americans Can Afford Cancer

WASHINGTON — Senator Hubert H. Humphrey, following the removal of his cancerous bladder in October of 1976, charged that very few Americans can afford the enormous cost of cancer treatment.

The Senator eloquently characterized cancer as a "thief in the night with a dagger that can hit you at any time." He noted with great concern that cancer also strikes approximately 35% of all Americans who have absolutely no health insurance.

Responding to the question: "Can the average American afford the financial expense of cancer?" Humphrey said:

"No. No way not unless they have the best in health insurance policies. . . Only a few millionaires can afford cancer."

Stressing the importance of cancer insurance, Humphrey stated that

"there's a role for those private policies in fact, I have one."

"There's a place for supplemental insurance in America," he continued. "I think people ought to look for it."

With deep sadness in his eyes, Humphrey told of his brother who had cancer, but no medical insurance. "He lived only a short period of time and spent over \$14,000 for hospital and surgical costs."

Humphrey told of a distressing phone call he had received moments before our interview. A friend, stricken with terminal cancer for three years who had been in and out of the hospital, had just succumbed to the dreaded disease.

"Fortunately," the senator noted, "her husband is very wealthy. But I know that it cost him, literally, hundreds of thousands of dollars."

*The late Hubert H. Humphrey, former U.S. Senator and Presidential Candidate, once said about the high cost of cancer treatment in this exclusive newspaper interview he urged every American to seek cancer insurance coverage.*

**BUT CANCER DOESN'T STRIKE ONLY PROMINENT PEOPLE LIKE HHH. IT ALSO STRIKES FOLKS LIKE YOU** — folks who might not be able to afford the . . . enormous cost of cancer treatment . . . as Senator Humphrey noted. The American Cancer Society estimates that 55 million Americans living today will become victims of this dread disease.

### BUT YOU DON'T HAVE TO STAND ALONE IN THE FIGHT AGAINST CANCER.

Here are letters from just a few of our grateful policyholders:



"I am devoutly grateful to your company for the protection it affords. Little did I think I would ever be a victim of cancer, but no one ever knows."  
Rev. N.H. Meibert,  
San Antonio, TX



"I am writing to tell you how thankful I was to receive payment for my Cancer policy, and you can believe I will be telling all my friends about your company. It has sure lightened our expense load so we can see our way out."

Metta West, Zephyrhills, FL



"I have been very pleased with the service of my claim. I have faith in your company. Thank you for your promptness."  
Mrs. Jessie Murray, Joplin, MO



"It is difficult for me to convey my thanks and gratitude. The amount, to my way of thinking, was more than fair. Union Fidelity Life Insurance Company is still the greatest."  
H.F. Simpton, Sausalito, CA



"I have no other policies. Have had no payment on them. Have two claims and you have cooperated 100%."  
Henry Banz, Belmar, NJ

## VIOLATIONS

*Page 1 of the Advertisement*

*Violation 1.*—The policy is designated *\$150,000 Cancer Plan*. This designation is misleading and deceptive because it is virtually impossible for the consumer to collect benefits to or approaching the policy limit. The company is or should be aware of this impossibility. First, the company's own loss ratio and claims payment history is indicative of this conclusion. Second, the benefits and risks covered under the policy are inconsistent with actual medical experience in the treatment of the various forms of cancer. In order to collect the available benefits in full, the consumer would have to have cancer diagnosed more than 120 days after policy issuance and, in the 36-month period immediately after diagnosis, be confined to a qualified hospital for a minimum period of 555 consecutive days. Because the policy pays only actual costs, if the daily hospital charges are less than \$138, it is literally impossible to collect the maximum. (This provision also violates section 8 of Regulation 1973).

*Violation 2.*—The format of page 1 gives the appearance of being a certificate of eligibility. This certificate has the tendency to mislead or deceive the consumer into believing that he or she has been specially selected to apply for this coverage and that he or she is automatically eligible. This is not true, as most recipients of the certificate are selected only because they appear on a mass-mailing list purchased or acquired by the company. The individuals appearing on these lists are not individually screened nor are they selected on the basis of predetermined standards of eligibility. Further, their eligibility is not guaranteed in that each recipient of the certificate is subject to rejection because of pre-existing conditions as would any other consumer applying for this policy.

*Violation 3.*—The seal on the lower right hand corner of the certificate has the capacity to mislead or deceive. The seal, bearing an eagle, stars and stripes, and the words "SECURITY. SERVICE AND PROTECTION" is designated "Official Seal." The implication or appearance is that it is associated with or issued by a governmental authority. The seal is meaningless and it is not issued or approved by or under the authority of any governmental or private agency or association.

*Violation 4.*—The certificate offers a free gift if the application is mailed by a certain date. The so-called "free gift" is merely an incentive to apply promptly. In fact, it is merely part of the promotional material and some form of free gift is offered or given to all mass-mailing applicants regardless of the time they apply. Consequently, the deadline date given and the implication that a free gift is dependent upon a prompt response by the consumer are illusory. Thus, the consumer may be misled or deceived.

*Violation 5.*—The statement “. . . provides benefits for cancer treatment in addition to any group insurance plan or Medicare” is misleading and deceptive because if these other plans have coordination of benefits provisions then the benefits offered by the company plan are “instead of” or “in lieu of,” rather than “in addition to,” these other benefits.

*Page 2 of the Advertisement*

*Violation 6.*—In the text of the letter are cited various statistics concerning the number of persons who will be affected by cancer and the costs associated therewith. The statistics are stated as facts. They are not facts, but estimates. The failure to designate them as estimates where they appear in the letter has the tendency and capacity to mislead and to create a false impression.

*Violation 7.*—The letter emphasizes the \$150,000 gross benefits available. Because it is highly unlikely, if not impossible, to collect this magnitude of benefits, this emphasis creates a false impression which has the tendency or capacity to deceive. (See *Violation 1* above).

*Violation 8.*—The statement in the letter, “the rest of the facts about the cancer plan are inside,” is not true. There is not a full statement of the extent of the limitations and exclusions stated inside, nor are other facts (such as overall costs, other cancer-related plans available from the company, or loss ratio and claims payment history) stated. All of these omitted facts are material and relevant to the decision to acquire the policy. The omission of these facts renders the advertisement incomplete and has the capacity to mislead the consumer.

*Violation 9.*—The statement in the letter “the cost is reasonable . . . as little as \$3.25/month” is misleading. The \$3.25/month figure is the premium for the company’s \$100,000 plan whereas all other statements in the letter pertain to the \$150,000 plan. This has the capacity to mislead the consumer to believe the policy is less expensive than it actually is in relation to the benefits received. Furthermore, the determination as to the reasonableness of the cost can be made only after a sufficiently complete statement of all material facts about the policy benefits and other plans is available. These facts are omitted making the statement deceptive.

*Violation 10.*—A portion of the letter stated “. . . we’re offering you the opportunity to be protected by the UFL \$150,000 Cancer Benefit Plan. The plan will pay you cash for cancer treatment both in and out of the hospital. And every penny of the money is paid DIRECT TO YOU . . .” This statement has the tendency to mislead and deceive. First, it is highly unlikely that the consumer will in fact collect every penny of benefits (see *Violation 1* above). Second, few, if any of the available benefits cover treatment out of the hospital, yet the statement creates the impression of full coverage in or out of the hospital.

*Violation 11.*—The entire thrust of the letter and the format employed has the tendency to create fear or trepidation in the mind of the consumer with regard to the probability of getting cancer and its subsequent cost. By emphasizing the estimates of the incidence of cancer and by depicting and quoting well-known and respected public figures as being victims of cancer, an atmosphere of fear and anxiety is promoted in which the consumer may be misled about the need for and the benefits of the company's cancer benefit policy. The emphasis placed upon the emotions associated with cancer rather than the actual benefits of the plan has the tendency to mislead.

*Violation 12.*—The so-called "official seal" has the capacity and tendency to mislead and deceive. (See *Violation 3* above).

*Page 3 of the Advertisement*

*Violation 13.*—The statistics utilized are taken from the American Hospital Association and the American Cancer Society, are only estimates, and should be designated as such. Furthermore, even as estimates, their use has the capacity to mislead because the estimates fail to cite necessary demographic, occupational, social and environmental factors which create variations in the incident and effect of cancer.

*Violation 14.*—The recitation of the gross economic cost of cancer to the American people is misleading because it fails to state clearly and completely the factors upon which the \$3 billion annual cost is based. There is no indication that the \$3 billion cost includes many factors such as wage loss and out-of-hospital expenses which are not covered by the cancer benefit policy. The use of the gross economic figure has the tendency to mislead the consumer.

*Violation 15.*—The statement that the "average cancer hospital stay is twice as long as other hospitalization" is misleading and deceptive particularly when it is included in a portion of the text emphasizing the high cost of cancer treatment. The statement is not sufficiently complete because it omits the actual length of a hospital stay due to cancer which, according to a survey by the National Cancer Institute (and others), is between two and three weeks, with a substantial portion of hospitalizations under thirty days.

*Violation 16.*—The statement that "cancer costs include higher fees for physicians services, drugs, nursing care and sick room equipment" has the capacity and tendency to mislead because it gives no indication as to the actual costs incurred or the base costs against which cancer costs are compared. Furthermore, the inclusion of this statement is deceptive because it implies that all the stated factors are covered by the policy.

*Violation 17.*—All references on this page to \$150,000 cancer plan or cancer benefits is misleading and deceptive because the benefits of the policy are set up in such a way as to make it highly unlikely such substantial benefits will be received.

*Violation 18.*—The statement that “all cancer benefits are paid in cash direct to you . . .” has the capacity to mislead and deceive the consumer. (See *Violations 1 and 10* above).

*Violation 19.*—The recitation of Hospital Confinement Benefits set forth within the section entitled “Cancer Benefits Summary” has the capacity to mislead because the reduction of benefits after the first seven days is set forth in smaller print than that used to indicate the increased benefits for the first seven days. The statement is not sufficiently clear and complete to avoid deception because it fails to include both the restrictive definition of hospital confinement, found in the underlying policy, and the restrictions on the type of institution covered, found in the exceptions and limitations portions of the policy and the advertisement. It also fails to include any reference thereto.

*Violation 20.*—The recitation of physicians benefits has the capacity to mislead and it is not sufficiently clear and complete to avoid deception because it is unclear whether the coverage is for actual physician charges up to a limit or whether there is a flat sum paid regardless of actual charges. The policy appears to provide for payment of a flat sum. It is also unclear from a comparison of the policy to the advertisement whether the exclusion of charges by the surgeon performing surgery is applicable only to those charges directly associated with the surgery or whether all charges by said physician are excluded if he or she also happens to be the surgeon performing surgery.

*Violation 21.*—The recitation of nursing benefits has the capacity to mislead and it is not sufficiently clear and complete to avoid deception. First, it is unclear whether the payment is of actual charges or a flat sum (see *Violation 20*). Second, it fails to include or refer to the restrictive definition of in-hospital nursing services found in the policy.

*Violation 22.*—The recitation of benefits for drugs and medicines including chemotherapy has the capacity to mislead and is not sufficiently clear and complete to avoid deception. First, because such recitation is stated in terms of a percentage of hospital confinement benefits it is subject to the same criticisms as those set forth in *Violation 19*. Second, the advertisement makes reference to chemotherapy whereas the policy does not. Third, it appears the policy will pay actual charges up to \$375 only if said actual charges are not greater than 10% of the hospital confinement benefits. Thus, a consumer could incur \$375 worth of charges in the first week for drugs and be denied a substantial portion of the payment because the actual cost exceeded 10% of the confinement benefits. This limitation is not sufficiently clear to avoid deception.

*Violation 23.*—The recitation of the surgical benefits is unclear and has the tendency to mislead. The benefits cite \$45 to \$750 per operation, yet the actual benefits set forth in the policy surgical schedule are substantially less than the \$750 promised. Of the forty surgical procedures listed in the surgical schedule, only four pay the full amount. The average is

less than \$450 per surgical procedure; thus, the method of stating benefits is misleading.

*Violation 24.*—The recitation of the anesthesia benefits is deceptive and incomplete because it fails to state that the anesthesia will not be covered if the anesthesiologist is employed by the hospital.

*Violation 25.*—The recitation of blood and plasma benefits is not sufficiently clear and complete to avoid deception because it fails to include references to any credits the consumer may receive for blood replaced by donors.

*Violation 26.*—The recitation of X-ray, radiation and cobalt therapy benefits is not sufficiently clear and complete to avoid deception because it fails to set forth the exclusion of diagnostic X-rays or other diagnostic procedures or laboratory tests related to this treatment, which exclusion is set forth in the actual policy.

*Violation 27.*—This recitation of ambulance benefits is deceptive and it is not sufficiently clear and complete. It fails to include the restrictive definition of "hospital confinement period" set forth in the policy. It also fails to set forth the requirement that the consumer be admitted as a resident patient in order to collect the benefits.

*Violation 28.*—The recitation of extended hospital benefits is not sufficiently clear to avoid deception and it has the capacity and tendency to mislead and deceive. First, it is unclear from the statement that the policy only pays actual charges on a per diem basis. The policy does not pay \$7,500/month or \$250/day unless said charges are actually incurred on a daily basis. Second, the statement fails to include the limitation that the hospitalization must be within the overall 3-year coverage period of the policy. Thus, a person may be denied benefits before discharge from the hospital and before the full benefits are paid if said hospitalization continues beyond a point three years from the date the cancer was diagnosed. Finally, the statements fail to include any estimate as to what actual hospital charges may be so that the consumer will clearly see that there is a substantial likelihood that full benefits literally cannot be collected under the policy.

*Violation 29.*—The format of the cancer benefits summary is not complete because it fails to include a reasonable statement of limitations and exclusions. It fails to include a clear statement that cancer diagnosed during the first 120 days that the policy is in force is not covered for two years. It fails to state clearly that all benefits terminate three years from the date of diagnosis. Even though these exclusions and limitations are stated and critiqued elsewhere, they should be included in the benefit summary to permit a meaningful analysis by the consumer. The summary entirely omits a clear statement that the benefits are not provided for any other disease or incapacity may have been complicated or aggravated by such covered cancer or by the treatment given for such covered cancer.

*Violation 30.*—The offer of a “special free bonus” has the capacity to mislead because it is neither special nor free nor a bonus (see *Violation 4*).

*Violation 31.*—The format of the entire cancer benefits summary is not sufficiently clear or complete to avoid deception or misunderstanding because it fails to include any estimates or reliable figures as to actual costs which may be incurred by the consumer during the illness, which estimates could be used by the consumer in analyzing and evaluating the coverage offered by the policy.

*Page 4 of the Advertisement*

*Violation 32.*—The section beginning “cash paid for all forms of cancer” is not clear or complete and has the tendency to mislead. The policy itself provides strict standards for the diagnosis of cancer which standards do not include “all forms of cancer.” The phrase “you collect full benefits” is misleading because it implies collection of the dollar amounts set forth in the policy without reference to the limitations and exclusions which may reduce or even eliminate the actual dollar payments. Although there are no literal requirements of deductibles or co-payment, the consumer generally ends up paying some of the costs incurred because of the numerous limitations and exclusions to which the benefits are subject.

*Violation 33.*—The section “pays cash in and out of the hospital” has the capacity to mislead and deceive because most benefits under the policy require actual hospital confinement overnight.

*Violation 34.*—The section stating “cash paid in addition to any other plan, even group or Medicare” has the capacity to mislead because it fails to alert the consumer as to the likelihood or possibility of coordination of benefits provisions which may reduce overall benefits under such “other group plans” or Medicare. Such disclosure is necessary to insure that the consumer is aware that the benefits under the policy may reduce existing coverage of other plans thereby depriving the consumer of the “additional” cash.

*Violation 35.*—The term “guaranteed renewable for life regardless of physical condition” is deceptive and misleading because the policy will terminate three years from the date any form of cancer is diagnosed, regardless of the course of treatment of the cancer or the form. Even if no actual treatment is required and the cancer recedes, the consumer will not have the right to renew the policy.

*Violation 36.*—The section commencing “full benefits over 65” is misleading. The section pertains to exceptions and limitations and not to benefits per se. Thus, the reference to full benefits over 65 detracts from the purpose of the section. Furthermore, all exceptions and limitations are not set forth, particularly definitions of cancer, confinement period and benefits paid (which are more limited in the policy than they appear in the advertisement).

*Violation 37.*—The representation concerning the policy holder service is misleading and incomplete. Elsewhere in this report is an analysis of the performance of the policy holder service department, which indicates that in many cases there was a substantial delay in the response to questions asked by policy holders.

*Violation 38.*—The statement “one rate same benefits for all ages” is deceptive because during the first year of coverage there is a 120-day waiting period without a corresponding reduction in premium. Although this is the same for all policy holders, it is a delay which is not clearly stated.

*Violation 39.*—The use of testimonials is misleading and deceptive because some of said testimonials are quoted out of context and do not pertain to the policy offered for sale.

*Violation 40.*—The use out of context of statements made by Senator Humphrey is misleading and deceptive. (See *Violations 6 and 11*). The statement does not cite the newspaper in which the article appeared (The Florida Times-Union of Jacksonville; May 26, 1977), and it is edited in a misleading way because it excludes references to chemotherapy and criticisms of cancer policies.

McCabe then summarizes regulation 1-74, section 6(A) (1-8) which prohibits the use of deceptive words, phrases or illustrations. These regulations are set forth below followed by the apparent violations again keyed to pages of the advertisement.

#### REGULATION

##### *Deceptive Words, Phrases or Illustrations Prohibited*

(1) No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

(2) No advertisement shall contain or use words or phrases such as, “all”; “full”; “complete”; “comprehensive”; “unlimited”; “up to”; “as high as”; “this policy will help fill some of the gaps that Medicare and your present insurance leave out”; “this policy will help to replace your income” (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

(3) An advertisement shall not contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as describing a wait-

ing period as a "benefit builder," or stating "even pre-existing conditions are covered after two years." Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

(4) No advertisement of a benefit for which payment is contingent upon confinement in a hospital or similar facility shall use words or phrases such as "tax free"; "extra cash"; "extra income"; "extra pay"; or substantially similar words or phrases because such words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

(5) No advertisement of a hospital or other similar facility confinement benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement. When the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

(6) No advertisement of a policy covering only one disease or list of specified diseases shall imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

(7) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to, or substantially similar to the following: "This is a Limited Policy"; "This is a Cancer Only Policy"; "This is an Automobile Accident Policy Only."

(8) An advertisement of a direct response insurance product shall not imply that because "no insurance agent will call and no commissions will be paid to agents" that it is "a low cost plan," or use other similar words or phrases because the cost of advertising and servicing such policies is a substantial cost in the marketing of a direct response insurance product.

#### VIOLATIONS

##### *Page 1 of the Advertisement*

*Violation 1.*—The use of certificate of eligibility has the capacity and tendency to deceive prospective purchasers as to their selection for receipt of the advertising materials. There are no standards of eligibility on which the company bases its decision to solicit the named individual. The statement that coverage ". . . is guaranteed to you and members of your family who have not had cancer" is not sufficient to remedy the defect. The fact that the certificate is issued to

the named recipient has the capacity to mislead said recipient to believe that the restriction to those who have not had cancer is limited to members of the recipient's family only and not to the recipient himself.

*Violation 2.*—The use of the gold official seal on which is emblazoned an eagle and stars and stripes has the capacity to deceive prospective purchasers to believe that the policy has been approved, reviewed or authorized by an official governmental agency and thus is deceptive as to the nature of the policy.

*Violation 3.*—The emphasis on the inscription "\$150,000.00 Cancer Plan" has the tendency to deceive or mislead a prospective or actual purchaser as to the extent of the policy benefits payable and tends to exaggerate the likely benefits beyond the term of the policy.

*Violation 4.*—The omission of a clear and conspicuous statement on the certificate of eligibility that the benefits are limited to cancer only and do not cover some expenses of cancer treatment or related treatments is a violation of subsection (7). Many expenses associated with cancer treatment are covered by medicare or group insurance plans which are not covered by this offered cancer plan.

#### *Page 2 of the Advertisement*

*Violation 5.*—The use of the pictures of famous deceased people, all of whom had cancer, accompanied by the warning that the same thing could happen to the prospective purchaser, tends to exaggerate the nature and extent of the policy benefits and loss coverage because it fails to indicate whether or not the deaths were caused by cancer which the policy would cover, implies that somehow the policy will provide protection from cancer-related death, and leads to an emotional, rather than functional, response to the need for such policy.

*Violation 6.*—Statements such as "we can guarantee you financial protection up to \$150,000.00 to help you beat the disease" are misleading because the benefit structure of the policy is such that it is highly unlikely and in some cases impossible for the policy holder to collect benefits to the extent apparently guaranteed in the letter. The designation of the benefits as protection is misleading because in most cases the policy holder will still have financial obligations and losses which are not covered by the plan.

#### *Page 3 of the Advertisement*

*Violation 7.*—The statistics are not clearly identified nor are they sufficiently clear to avoid deception. The omission of the underlying facts on which cancer treatment expenses are computed and analyzed tends to mislead the prospective customer as to the benefits payable and losses covered and to exaggerate the benefits beyond the terms of the policy.

*Violation 8.*—The use of the words "up to \$—— per day" tends to exaggerate the benefits beyond the terms of

the policy because the policy is an indemnity policy paying actual expenses.

*Violation 9.*—The cancer benefit summary omits information pertaining to restrictions and limitations found in the policy itself which omission tends to mislead the prospective purchaser as to the benefits payable and the losses covered.

*Violation 10.*—The statement “Pays you up to \$150,000.00 Cash Benefits” followed by the statement “All cancer benefits are paid directly to you” exaggerates the benefits beyond the terms of the policy.

*Violation 11.*—The recitation of daily benefits payable with regard to extended hospital benefits is deceptive and misleading because it fails to state clearly the limits on the number of days covered and other restrictive definitions of those benefits appearing in the policy.

*Violation 12.*—The use of the illustration of the United States setting forth the estimated cancer cases by state is misleading because it omits information as to factors which made the estimated figures unreliable.

*Page 4 of the Advertisement*

*Violation 13.*—The pledge of Harry Dozer, that cash is paid for all forms of cancer is misleading as to the extent of the benefits and exaggerates said benefits beyond the terms of the policy because full benefits are not paid for all forms of cancer due to policy restrictions. In most cases the policy holder, because of the actual costs, will be required to incur additional obligations which may require co-payments.

*Violation 14.*—The Pledge “pays cash in and out of the hospital” has the capacity to mislead as to the benefits payable because most benefits are contingent upon hospital confinement.

*Violation 15.*—The Pledge “all benefits paid in cash . . .” has the capacity to mislead the public to believe that the policy will, in some way, enable them to make a profit from being hospitalized.

*Violation 16.*—The designation “additional cash” has the capacity to mislead the public to believe that the policy will, in some way, enable the policy holder to make a profit from being hospitalized.

*Violation 17.*—The Pledge “Guaranteed Renewability” has the capacity to mislead because it fails to set forth clearly the 3-year time limitation of the policy after the diagnosis of cancer.

*Violation 18.*—The exceptions and limitations pledge omits other substantive limitations in the policy, including restrictive definitions and provisions limiting coverage to actual charges incurred. All limitations, exceptions and reductions are not fairly and accurately described.

*Violation 19.*—The recitation of the premium due omits a clear statement of the 120-day waiting period before immediate coverage is provided, thus having the capacity to mislead the prospective purchaser into believing coverage is immediate.

McCabe quotes sections 6(b) (1-3) and 6(c) (1-3) of the Massachusetts regulations which require insurance companies to prominently display exceptions, reductions, limitations and pre-existing conditions in policies to provide the consumer with maximum information and prevent misrepresentation.

The following apparent violations of these regulations were found:

*Violation 1.*—The advertisement fails to include all substantive exceptions, restrictions, and limitations affecting the benefits payable under the policy thus giving the advertisement the capacity to mislead. This is primarily true of restrictive definitions of losses covered by the policy.

*Violation 2.*—The use of the certificate of eligibility and the statement thereon that coverage is guaranteed to the named recipient implies that the applicant's physical condition will not affect the issuance of the policy.

*Violation 3.*—The application which is part of the advertisement fails to provide an adequate question or statement reflecting the pre-existing conditions provisions of the policy. The "Representation and Agreement" provision of the application form is not sufficiently clear when viewed in relation to the certificate of eligibility and the impression such certificate may make on the policy holder.

Regulation 1-74, Section 7 relates to the necessity for disclosing policy provisions relating to renewability, cancellability, and termination as follows:

When an advertisement refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability and termination and any modifications of benefits, losses covered or premiums because of age or for other reasons in a manner which shall not minimize or render obscure the qualifying conditions.

McCabe cites the following *violation*:

The format of the advertisement is such that the gross amount of benefits payable (\$150,000) for cancer treatment is emphasized. The advertisement does not clearly and sufficiently disclose provisions relating to termination and modification of benefits and losses covered and thereby minimizes or renders obscure the qualifying conditions. Restrictive definitions of the various benefits payable are not adequately disclosed nor are the waiting and probationary periods, depending on which cancer is diagnosed, sufficiently clear. The relationship between the 3-year termination period and the policy holder's ability to collect the benefits of the policy is also obscured by the format of the policy.

Regulation 1-74 relates to the use of testimonials or endorsements by third parties. They require that testimonials be genuine and represent the current opinion of the author and if the person making the testimonial has been paid or had any financial interest or benefit from the company, this must be disclosed to the consumer.

McCabe cites the following *violation* :

*Violation 1.*—The use of testimonials by the insurer is misleading and deceptive in that some testimonials used are solicited by the insurer, which solicitation is not disclosed. Furthermore, in some cases, the text of the testimonial is taken out of context thereby altering the impression intended. (Note: These facts also violate Section 9, A–D of Regulation 1973).

Regulation 1–74, Section 9, A–C relates to the use of statistics. The insurance company cannot use irrelevant facts, must cite the source of any statistics, the statistics must be accurate. The company is prohibited from using an unusual amount paid for a unique claim as an advertisement.

The following violations of these sections were noted :

*Violation 1.*—The use of statistics regarding the cost and incidence of cancer in America followed by a statement of the plan benefits, implies that all costs and incidents are covered by the benefits available under the plan. Such statistics are irrelevant with regard to the plan's benefits.

*Violation 2.*—The newspaper from which the interview with Senator Humphrey was taken is not cited in the advertisement and therefore the reliability of the statistics contained therein is questionable.

*Violation 3.*—The use of a portion of the newspaper interview with Senator Humphrey in which he emphasizes the need for cancer insurance and states the hospital and surgical expenses of his brother, constitutes the use of irrelevant facts because it does not disclose whether said expenditures were typical nor does it break down these expenditures by category. Further, it does not disclose whether said expenditures would be covered by the policy offered.

*Violation 4.*—The use of the “gold official seal” implies that the insurer or policy has been endorsed or approved by an association or other entity. The fact that the gold seal is issued by the company and is meaningless is not disclosed. (The above are also violations of Section 10 of Regulation 1973).

Regulation 1–74, Section 12 (B) says :

An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed, or accredited by any division or agency of this State or the United States Government.

The following violation is cited :

*Violation 1.*—The use of the gold “official seal” on which is emblazoned the stars and stripes creates the impression that the policy is approved, endorsed, or accredited by a division or agency of the United States. (This is also a violation of Section 13C of Regulation 1973).

Regulation 1-74 prohibits the insurer from representing that there is a special offer unless it is true so that the applicant will enjoy special advantages not available to others. The rule prohibits any statement or implication that only a certain number of policies will be sold or that a time is fixed for the discontinuance of the sale unless such is the fact. A portion of the regulation says:

An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this State unless there has been a lapse of not less than 6 months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period.

The following violations are cited:

*Violation 1.*—The advertisement directly represents that a special free bonus is available for a limited time and implies, by the use of the certificate of eligibility, that the offer is available only to a specific group when such is not the case. This method is one of the usual forms of advertising by the insurer.

*Violation 2.*—The advertisement and enrollment period for the policy is offered less than six months from the date of the immediately preceding enrollment period. (These are also violations of Sec. 16, A-C of Regulation 1973.)

Regulation 1973, Section 5, A-C requires that marketing methods must be complete and clear to avoid deception, they must be truthful and not misleading in fact or in implication.

McCabe charges "the cumulative effect of violations 1-40 cited above under regulation 1-74 are violations of Section 5, A-C of the 1973 regulations."

Regulation 1973, Section 6, A-C relates to marketing methods addressing the benefits payable, losses covered or premiums payable. They prohibit the use of deceptive words, phrases, or illustrations as well as restricting the use of pre-existing conditions and other exceptions, reductions and limitations.

McCabe notes the following violations:

*Violation 1.*—The cumulative effect of Violations 1-19 under Section 6A of Reg. 1-74 and Violations 1-3 of Sections 6B-C are violations of Section 6A-C of Regulation 1973.

*Violation 2.*—The marketing method employed in the advertisement overemphasizes the exceptional or catastrophic risk and exaggerates the potential out-of-pocket cost of cancer treatment, especially in view of the benefits offered, so as to invite the purchase of the policy for emotional rather than functional reasons (subsection 11).

*Violation 3.*—The policy is offered to be in addition to and therefore supplemental to Medicare. The Disclosure, therefore, is inadequate because it fails to divulge the extent to which Medicare deductibles are covered; the extent to which the co-insurance policies of Medicare are covered; and the extent to which no benefits are payable (subsection 12).

*Violation 4.*—The benefits are inadequately disclosed because they fail to utilize the required categories of benefits, to wit: Benefit in Extended Care Facilities, Benefits in Nursing Homes and Other Benefits (subsection 12).

Regulation 1973, Section 7 relates to the form and content of an application for insurance. Among the regulations is a statement required to be printed in each policy advising the consumer that it does not pay benefits equal to 50 percent of the average cost of hospitalization in the state. Pre-existing conditions or other limitations of liability must be clearly and unambiguously stated.

McCabe offers the following violations:

*Violation 1.*—The application fails to include the required statement concerning actual hospital costs as defined by the Massachusetts Division of Insurance Hospital Cost Standards.

*Violation 2.*—The application fails to state clearly and unambiguously in negative terms the nature and extent of the exclusion for pre-existing conditions or conditions diagnosed within the first 120 days of coverage.

*Violation 3.*—The application fails to disclose the extent to which benefits are contingent upon hospital confinement.

*Violation 4.*—The application fails to adequately disclose the premium rate for the policy solicited.

*Violation 5.*—The application fails to adequately disclose the terms of renewability and premium guarantee.

The Attorney General's Regulation No. I.B requires:

No statement or illustration shall be used in any advertisement which creates a false impression of the grade, quality, make, value, currency of model, size, color, usability, or origin of the product offered, or which may otherwise misrepresent the product in such a manner that later, on disclosure of the true facts, there is a likelihood that the buyer may be switched from the advertised product to another.

McCabe cites this apparent violation:

*Violation 1.*—The emphasis on the gross dollar amount of benefits payable without a clear and complete statement of limitations, restrictions and exclusions creates a false impression with regard to the quality of the product offered. Once the facts are disclosed, including the fact that, as part of its marketing method, the company routinely attempts to solicit additional business from present policyholders by selling riders or switching the policyholder to other policies sold by the company, there is a likelihood that the buyer may be switched from the advertised policy to another.

The Attorney General's Regulations IV.A and B prohibit misrepresentations to consumers as follows:

A. No claim or representation shall be made by any means concerning a product which directly, or by implication, or by failure to adequately disclose additional relevant information, has the capacity or tendency or effect of deceiving buyers or

prospective buyers in any material respect. This prohibition includes, but is not limited to, representations or claims relating to the construction, durability, reliability, manner or time of performance, safety, strength, condition, or life expectancy of such product, or financing relating to such product, or the utility of such product or any part thereof, or the ease with which such product may be operated, repaired, or maintained or the benefit to be derived from the use thereof.

B. No advertisement shall be used which would mislead or tend to mislead buyers or prospective buyers, through pictorial representations or in any other manner, as to the product being offered for sale. Where price is featured in advertising, any picture or depiction utilized in connection therewith, shall clearly indicate the exact product being offered for sale at the advertised price.

McCabe offers these violations:

*Violation 1.*—The exaggerated effect of the risks of cancer accompanied by the emphasis on the gross benefits payable, without adequately disclosing limitations and relevant information (such as hospital costs), has the capacity and tendency to materially mislead prospective buyers with respect to the usefulness of the policy.

*Violation 2.*—The pictorial representation of cancer facts and statistics together with the statement of policy benefits tends to materially mislead the consumer in the evaluation of the product.

The Attorney General's Regulation XV A-C says:

Without limiting the scope of any other rule, regulation or statute, an act or practice is a violation of Chapter 93A, Section 2 if:

A. It is oppressive or otherwise unconscionable in any respect; or

B. Any person or other legal entity subject to this act fails to disclose to a buyer or prospective buyer any fact, the disclosure of which may have influenced the buyer or prospective buyer not to enter into the transaction; or

C. It fails to comply with existing statutes, rules, regulations or laws, meant for the protection of the public's health, safety, or welfare promulgated by the Commonwealth or any political subdivision thereof intended to provide the consumers of this Commonwealth protection.

McCabe offers these shortcomings:

*Violation 1.*—It is unconscionable to sell a policy which, under certain circumstances, makes it literally impossible to collect the benefits promised.

*Violation 2.*—It is unfair and deceptive to fail to disclose material facts (such as loss ratios, denial rates, actual hospital and related charges and exclusions and limitations) to a prospective buyer because the disclosure of these material facts might have influenced the buyer not to enter into the transaction.

*Violation 3.*—Each and every of the aforementioned violations and the cumulative effect thereof is a violation of Regulation XV.C.

Regulation 2-74, Section 20 relates to specified disease or specified accident policies requiring them to use a set disclosure form.

McCabe offers this violation :

*Violation 1.*—The disclosure form utilized by the company fails to accurately list all benefits and fails to list all exclusions, reductions and limitations in a manner that does not encourage misrepresentation of the actual coverage.

(2) *Touche Ross & Co.*

On December 8, 1978, Touche Ross & Co. submitted their study to the Massachusetts Insurance Department as part of the Union Fidelity market conduct examination. Their report reaches the following conclusions:

A. UNION FIDELITY ADVERTISING AND PROMOTIONAL MATERIALS  
SOMETIMES CONTAIN ERRORS OR MISSTATEMENTS

- The Rural American Group Trust letter sent out by the Company says accidental death is 26.4 percent higher among people who live on farms when the incidence is only 15.9 percent higher. The Direct Consumer Trust mailing states that 10,300,000 Americans were permanently disabled by accidents in a year when the fact is only 370,000 of this number (or 3.6 percent) were permanently disabled.
- Testimonial letters reprinted by the company were misused. Positive portions of one letter were used but negative comments about the company's claims processing procedures were omitted. Two of sixteen testimonial letters came from people who had never submitted a claim. In one case, the letter was written prior to the issuance of the policy by the company.
- The company purports to offer special low group rates which are not much lower than individual policy rates. For example, the \$200,000 cancer insurance coverage is offered to individuals at \$5.85 a month and offered to groups for \$5.54 a month, or a difference of 31 cents a month.
- Promotional materials also exaggerate potential benefits. Touche Ross tried to determine the events that would have to take place before the individual could collect the promised \$200,000 in cancer benefits. "Since coverage does not extend beyond three years," said the report, "an insured hospitalized continuously for three years could collect \$173,910 using the company's advertised average room and board rate of \$158 per day." The practical effect of this analysis is to say that no one will ever collect the full \$200,000 and that the promise of this amount is illusory.

#### B. COMPLAINT PROCEDURES NEED TO BE STRENGTHENED

The report says:

Based upon our observations in these areas, the Massachusetts Division of Insurance should consider recommending that the company implement standardized procedures to insure that all written complaints/inquiries and significant telephone complaints/injuries are properly recorded, summarized into meaningful categories, and disposed of in a timely manner. A periodic independent review of these activities by responsible Company management might also be an appropriate recommendation from the Division of Insurance.

As an aside, the report notes that all 23 States selected for purposes of the study had complained to the Company about some aspects of its advertising and had requested that Union Fidelity change certain related items.

#### C. LITTLE CONTROL OVER AGENTS

The report notes that Union Fidelity contracts with general agents to market its policies. The general agents in turn contract with sub-agents. No personnel records are maintained by the Company. The Company does not conduct training courses for agents and does not prepare any educational materials for the purpose of training agents.

Most of the agents hired have previous experience—but 20 percent of the sample reviewed had no previous work history or insurance experience:

There were twenty-nine (29) agents terminated during the examination period. Seventeen (17) of the twenty-nine (29) were terminations resulting from Massachusetts Division of Insurance investigations. The annualized agent turnover during the examination period was approximately 83%.

The company admitted buying mailing lists for its mass marketing effort.

#### D. THERE IS LITTLE DONE WITH RESPECT TO UNDERWRITING

For cancer policies, applications are rejected only if the individual reports that he or she has cancer.

#### E. LOW LOSS RATIOS

The Company's total loss ratio for insurance sold in Massachusetts in 1977 was 17.6 percent. The Company's two biggest cancer insurance policies had loss ratios of 24.6 and 3.4 percent respectively. These figures are cumulative since the issuance of the plan.

#### F. CLAIMS SETTLEMENT PROCEDURES: HIGH RATE OF DENIAL

Touche Ross analyzed 5,335 claims and learned that 1,119 or 21 percent of them were denied in a year. Of 72 paid claims, the average

payment was \$330. Most of the unpaid claims are rejected because the claim is not covered in the terms of the policy. It took an average of 25 days from the filing of a claim for an individual to be paid.

(3) *RL Associates*

The Massachusetts Department of Insurance contracted with RL Associates to interview a number of policyholders who had purchased Union Fidelity dread disease or cancer insurance policies. The Department felt that the testimony of policyholders would add greater depth to their understanding of cancer insurance issues.

By way of background, Union Fidelity is an insurance company based in Trevese, Pennsylvania which specializes in the mail order sale of health insurance. Cancer insurance policies account for about 20 percent of their sales. The remainder consists mainly of Medicare supplementary health insurance policies.

RL Associates reached these major conclusions :

- The single most significant characteristic of policyholders is their old age. Only 10 percent of their policyholders are under age 60. In keeping with their age, they exhibit a number of other associated demographics, such as low income and a high number of widows.
  - More than three-fourths of the entire sample was covered by Medicare. Given the high average age, this is not surprising, but it is significant from the standpoint of coordination of benefits. Similarly, despite their age, two thirds of the sample were covered by Blue Cross/Blue Shield. Only about 5% of the entire sample had neither Medicare nor Blue Cross/Blue Shield coverage.
  - About two-thirds of the total sample knew they had a policy with Union Fidelity. "Only about three-fifths of those who Union Fidelity says have a cancer policy recall having the policy. This drops to half of those 80 years of age or older."
  - Union Fidelity sells policies through the mail thus there was nothing to report about the habits of agents. Over 80 percent of those interviewed remember reading or seeing a brochure. Most people said they read the entire brochure.
- Respondents gave a wide variety of answers to questions about what they specifically remembered from reading the brochure. The two most common answers, which between them were given by about half of all respondents, touched on the costs and incidence of cancer.
- The primary motivations cited by respondents for choosing the Union Fidelity was that it was the only cancer policy they had ever heard of or that it was made conveniently available through the mail. The underlying motivations for buying a cancer policy at all were related to fear of the disease itself or to its cost and widespread incidence among the population.

- Paradoxically, few people understood the benefit provisions of their Union Fidelity cancer insurance policy. For example, more than half of policyholders did not know if there was a time limit on benefits . . . When asked what part the policy would pay of a total hospital/doctors bill of \$20,000, only about 5% of those who even knew they had cancer policies estimated less than half this amount, the more accurate amount. One quarter said they would receive all of the \$20,000, and more than half admitted that they did not know. Given the normal payout of about 35%, it is clear that most respondents either grossly overestimated or had no idea what their policy benefits really are.
- A small minority of those interviewed had ever filed a claim on their cancer policies. About one-fifth of them said they had other Union Fidelity insurance, with 12 percent saying they had a Medicare supplement or similar policy. According to the study, "about half of all respondents had such a policy, with the great majority having a Medicare supplement policy." Comments the report, "this discrepancy is probably connected to the advanced age of the respondents."

RL Associates concluded their study as follows:

**Union Fidelity sells cancer policies almost exclusively to elderly people through the mail by emphasizing the costs and financial burdens of cancer. This sales approach results in policyholders who have little knowledge of the actual benefits provided by Union Fidelity and who also have overlapping coverage with Blue Cross/Blue Shield and/or Medicare.<sup>1</sup>**

<sup>1</sup> Union Fidelity's response filed on March 7, 1979, denied the alleged violations point for point. Union Fidelity charged that rather than looking at the policies as a whole, the authors of the report "dissected phrases and put individual words under a microscope. Union Fidelity charges that the study was not objective, saying the conclusions of the study were "rooted in a desire to find fault." Union Fidelity defended their use of \$250,000 recovery figures saying it was indeed possible for a person to collect this amount under their policies. They added that to say that the seal they use in their advertising is misleading and intended to convey the notion of affiliation with the U.S. Government is totally absurd. They also deny the charge that their advertising is heavily loaded toward cancer statistics and is designed to keep the customer's attention on the fear of cancer rather than on the benefits to be provided in the Union Fidelity policy. On January 30, 1980, Senior Counsel Val J. Halamandaris asked Union Fidelity lawyer Judah Sommers for any comments to the above study. No response has been received as of the time this publication went to press.

MARKET CONDUCT EXAMINATION : WASHINGTON NATIONAL  
INSURANCE COMPANY

In November of 1978, the Massachusetts Department of Insurance also released a market conduct examination of the Washington National Insurance Company of Illinois. Assisting the Department with the study was a team of auditors from the Coopers and Lybrand firm, and an attorney, Paul Gitlin. The study related to dread disease policies sold in the State by representatives of the company under the sponsorship of newspapers or motor clubs. It should be noted that Washington National no longer sells cancer insurance.

The cancer expense policy marketing methods and material used by the company appear to violate numerous Massachusetts statutes :

(1) The marketing materials did not contain information concerning the average financial cost of the treatment of cancer. Without such data it is impossible to determine if the policy benefits available are worth the premiums charged.

*The failure to disclose the average financial cost of cancer* appears to violate Massachusetts Law . . . because this disclosure, if made, might influence a prospective buyer to seek alternative insurance coverage.

(2) The marketing methods used misrepresent the effect of other insurance policies on the consumers retention of benefits provided since the material stressed that the cancer coverage will pay expense benefits regardless of the existence of other insurance. While that representation is technically true, it is nevertheless misleading because it fails to inform the consumer that there exists a very real possibility in Massachusetts that the benefits provided by this policy will reduce any benefits expected from the consumers other insurance policies, such as, Blue Cross/Blue Shield.

*The misrepresentation of the effect of overlapping insurance coverage* appears to violate Massachusetts Law . . . because it has the tendency to mislead the public about the extent of insurance proceeds reasonably expected to be paid.

The effect of other insurance companies coinsurance or co-ordination of benefit provisions should be clearly disclosed. The language promoting the fact that money will be paid regardless of the existence of other insurance should be stricken. The marketing material is not sufficiently clear and complete to avoid deception or the capacity to mislead or deceive.

(3) While the material contains numerous examples of unclear or incomplete assertions, the most critical concerns the disclosure of the policy's exemption provision. This provision is written in such a way that repeated readings are required to understand it.

The use of *unclear language* appears to violate Massachusetts Law because it has the capacity to mislead or deceive.

(4) Another example of unclear or incomplete statements involves the longevity of the insurance coverage. The policy is promoted as one that will continue for as long as premiums are paid, membership in the sponsoring organization continues, and the 'master policy' is in effect. The overall impression is created that the circumstances of policy termination are fundamentally under the control of the consumer. This is not true because the 'master policy' is nothing other than a restatement of the individual policy with one major exception—it is cancellable by either party upon sixty days notice, prior to the anniversary date of the policy.

*This use of incomplete information creates an improper impression of the cancellability of the coverage and therefore appears to violate Massachusetts Law.*

The effect of the contractual relationship between the insurance company and the sponsoring organization on the possibilities of renewal should be clarified.

(5) The Company uses misleading statements and omits additional information concerning the benefits provided which misleads or has the capacity to mislead purchasers about the extent of the benefits payable.

*The promotional material misstates or misleads consumers concerning the extent of benefits provided and therefore appears to violate Massachusetts law.*

(6) The Company fails to specifically inform the prospective purchaser that the policy covers cancer only. Although the material states that the policy is a cancer expense policy, there is no indication, other than in the confusingly drafted exemption provision, that the policy coverage is limited to costs incurred as a result of cancer.

*The failure to conspicuously state the limited nature of the policy appears to constitute a violation of Massachusetts Law.*

(7) The Company's brochure is replete with facts and figures concerning cancer. The inclusion of this otherwise superfluous information creates an emotional atmosphere of concern about contracting the disease. Insurance purchases should be contemplated and made for functional reasons, and not as a result of an artificially created fear of being inflicted with a particular malady. The infusion of this information has the effect of concentrating the consumer's attention on the disease and may trigger purely emotional responses to the purchaser's innate fear of cancer.

*The creation of a climate whereby the insurance purchase is made for emotional rather than functional reasons appears to violate Massachusetts Law.*

(8) The exception provision language employed by the Company effectively establishes a thirty day waiting period, but the company in its promotional materials fails to clearly disclose the existence of this waiting period. The coverage

under this policy includes only cancer first diagnosed after the expiration of thirty days from the effective date of the individual insurance contract. This creates a thirty day waiting period, which is not disclosed as such in the promotional material.

*The failure to disclose the existence and extent of the waiting period appears to constitute a violation of Massachusetts Law.*

(9) The documents do not contain a clear explanation of the cancellation, termination or renewal provision. The continuation of this policy is contingent on the continuation of the relationship between the company and the sponsoring organization. Either of these parties may cancel their contract with sixty days notice. This possible basis for termination is discussed in a question and answer section on the back page of the major promotional booklet, but the explanation creates a faulty impression of the actual relationship of the parties. (See Section 4 above).

*The failure to clearly disclose the full extent of the cancellation, termination or renewal policy appears to violate Massachusetts Law.*

The actual relationship between the Company and the sponsoring organization, and the effect of this relationship on the possibility of termination of the individual policy should be clearly disclosed.

(10) The marketing method used implies that the insurance plan is approved or endorsed by AAA, without disclosing the financial consideration they received from the company. The letter sent by the local AAA affiliates to its membership implies that this organization endorses this insurance product. In fact the local organization receives compensation in the form of a percentage of premiums collected.

*The failure to disclose the financial relationship between the insurance company and the sponsoring organization while at the same time implying an endorsement of the product appears to violate Massachusetts Law.*

(11) [T]he Company has used a substantial number of statistical references and statements derived from American Cancer Society publications. Not only does the company fail to identify the source (the American Cancer Society has asked the company not to use its name), but many of the references and statements are outdated. For example, the brochure contains an assertion that "cancer is on the increase," but the most recent American Cancer Society report indicates that the overall incidence of cancer has decreased slightly in the last twenty-five years, and that the death rate has been leveling or dropping (depending on the type of cancer).

*The use of statistical information without reference to its source . . . and the use of outdated and misleading statistics appear to violate Massachusetts Law.*

(12) *The documents fail to identify the form number of the policy . . . which appears to constitute a violation of Massachusetts Law.*

(13) The policy is marketed as a group policy when in fact it fails to meet the traditional tests for group policies. The name of the policy, AAA Group Cancer Expense Insurance Policy, the marketing methods, and the normal interpretation of statements used to promote the policy imply that the insurance offered is a "group policy." In fact, the policies issued are sold to individuals, and these individuals bear the total responsibility for premium payments. This policy should be characterized as a "franchise policy."

Although the Company claims that the existence of the group results in lower premium obligations for the members, the fact that the Company engages in absolutely no underwriting analysis in writing these policies argue against this contention. In addition, the company claims that non-affiliated individuals would have to pay a higher premium, but admits that it does not sell this policy to non-affiliated individuals.

*The practice of implying a group status when such is not the case appears to violate Massachusetts Law.*

The implication that this policy constitutes a group plan should be prohibited and the true characterization should be used.

(14) The commissions paid on this policy are paid to an organization which is not a licensed Massachusetts insurance broker. The Tri-County Auto Club receives a payment of 17.5% on the premiums paid by its members to the Company. The Company claims that this is an administrative fee, but the Auto Club does not engage in any meaningful administrative duties. In addition, the practice of basing payments on the amount of money collected is in keeping with the concept of "commission" and not with the concept of "administration."

*The payment of commissions on sales of insurance to non-licensed individuals appears to violate Massachusetts Law.*

The practice of paying commissions to unlicensed individuals should be curtailed.

Serious shortcomings were found in the Company's Cancer Expense Application Form:

(1) Although the benefits recoverable represent less than 50% of the cost of an average hospital stay, the application does not contain the required statement that "this policy is supplemental in its coverage and is meant to be purchased in addition to basic health insurance. This policy pays for —% of the cost of an average stay in a Massachusetts Hospital as defined by the Massachusetts Division of Insurance Hospital Cost Standards."

Calculation of the proportionate maximum payments per average stays in Massachusetts hospitals indicates that this policy will pay 23% of the cost of a short stay, 49% of an average stay, and 46% of a long stay. Since the payments possible do not exceed 50% of the average costs for these standard periods of hospitalization, the consumer should be informed of this fact so that additional coverage can be purchased.

*The Company's failure to include the required percentage reimbursement information on the application appears to constitute a violation of Massachusetts Law.*

(2) The application fails to clearly and unambiguously disclose the Company's preexisting condition exclusion provision. The only semblance of a disclosure concerning the preexisting condition exclusion is found in a question asked on the application. This question concerns whether any person to be covered under the policy has or has ever had cancer. The last part of this underwriting question indicates that any persons named will not be covered. While this procedure introduces the concept of the exclusion, it is neither a clear nor a complete statement of the Company's exclusion policy.

*The failure to include a clear and unambiguous statement of the Company's preexisting condition exclusion in the application appears to constitute a violation of Massachusetts Law.*

(3) The application fails to contain any of the additional information required by Massachusetts Insurance Division regulations. The application form is a very simple envelope size document containing almost no information. In addition to its failure to include the information described above in this report, the company fails to disclose: the existence and extent of the waiting period; the fact that the reception of some benefits are contingent on hospitalization; the annual premium rate (semi-annual rate is disclosed, but the more economic, annual rate is not); and the terms of renewability and premium guarantee; there is also no room provided on the application for the applicant's signature indicating that he/she understands the required disclosures.

*The failure to disclose this information . . . and the failure to include and disclose that a cheaper premium rate is available appear to constitute a violation of Massachusetts Law.*

(4) The application does not contain questions that elicit information concerning whether the insurance sought replaces other accident and sickness insurance. Massachusetts Insurance Division regulations require that a specific disclosure must be made if a consumer is replacing present coverage by purchasing a new policy. To effectuate this disclosure, the regulation also requires that any application ask questions designed to elicit this information.

*The failure to include questions designed to elicit this information appears to constitute a violation of Massachusetts Law.*

Serious problems were also found with the Cancer Expense Policy Form used by the Company. The Department said that "for the purpose of this review, we assumed that the cancer policy, marketed in Massachusetts, creates and evidences an individual insurance relationship with the policyholder."

The problems included:

(1) The policy does not contain a 'preexisting condition provision' on the first page. The insurance provided covers

expenses incurred for treatment of cancer which first manifests itself after the first thirty days of coverage. Thus, cancer is a preexisting condition excluded under the policy, but the disclosure of this fact is not labeled 'preexisting condition provision' nor is it placed on the first page of the policy.

*The failure to correctly label and disclose the preexisting condition exclusion appears to violate Massachusetts law.*

The exemption provision should be labeled "preexisting condition provision" and should appear on the first page of the policy.

(2) The preexisting condition test used is not reasonable. The policy exemption provision excludes cancer first manifest prior to the 31st day of coverage. Since the initial manifestation of cancer often produces no discernible symptoms, the ordinarily prudent person might not know at the time of contracting with the Company that the costs he incurs would be excluded from coverage.

*The use of a test for preexisting conditions other than one that would cause the ordinarily prudent person to seek medical assistance appears to violate Massachusetts Law.*

(3) The policy and the promotional material employ different standards for preexisting condition exclusions. The promotional material states that cancer first *manifest and diagnosed* prior to the first 31 days of coverage is excluded. The policy exclusion provision requires only that the disease was *manifest*. The differences are substantial since cancers manifest months or years before diagnosable symptoms appear.

*The use of a more restrictive exclusion in the policy than the one disclosed in the marketing material appears to constitute a violation of Massachusetts Law.*

(4) Room and board daily benefits for 60 continuing days of hospital confinement are not equal to the cost of a semi-private room. The policy provides payment of \$60 per day for the first 12 days of hospital confinement and \$30 per day thereafter. This level of reimbursement does not equal the average Massachusetts rate for a semi-private room.

*The use of internal limits on dollar benefits which do not equal the cost of semi-private room appears to violate Massachusetts law.*

(5) The policy is cancellable during the life of the insured, and the premiums may be increased. Although the material creates an impression that the policy is noncancellable as long as premiums are paid, the insurance coverage can be terminated by cancelling the contract between the Company and the sponsoring organization. The policy allows for a change in premium rates by reserving that right.

*Selling a specified disease policy which is cancellable during the lifetime of the insured and for which premiums may increase appears to be a violation of Massachusetts Law.*

(6) *The Company does not utilize the required disclosure form . . . which appears to be a violation of Massachusetts Law.*

The report also criticized the company for failure to institute procedures to investigate and resolve complaints.

The Company was criticized for lack of oversight of "its prescribed procedures and practices" particularly to make sure that the reasons for termination of agents are clearly disclosed.

In a November 27, 1978 letter, the Washington National Insurance Company through its Attorney Muriel Crawford, took exception to various aspects of the report. The Company wrote to the Department:

Many of the supposed violations cited in the Report stem from the supposition that the Tri-County Auto Club policy is an individual rather than a group policy. We maintain that this policy is indeed a group policy. . . . The payment of the entire premium by the insureds under the Auto Club policy does not, we submit, make this an individual rather than a group policy.

Washington National also maintained that their literature was not in violation of the regulations cited. They admitted that form numbers were missing and that some of the brochures used were dated. They denied any "commissions" were being paid to unlicensed individuals. They said that administrative fees only were paid to the Tri-County Auto Club. The Company said:

(The regulations) state that the approval by an association shall not be stated or implied unless such is a fact. Unquestionably, the Tri-State Auto Club does approve and endorse the policy since the Club is the policyholder. There is no 'proprietary or other financial relationship' between Washington National and the Tri-County Auto Club, except for payment for administrative work delegated to the Club by Washington National. This would not seem to be the type of proprietary or other financial relationship meant by the regulation.

## V. WHAT STATE REGULATORS SAY ABOUT CANCER INSURANCE

In the course of this investigation of cancer insurance and the broader topic of dread disease insurance, the Committee sent a questionnaire to all 50 State insurance commissioners. This is the first time that all State insurance commissioners have been polled on this important subject.

In drafting the questionnaire, the Committee staff took the conclusions reached by *Consumer Reports* in their June 1978 evaluation of cancer insurance and asked State officials if they agreed with each of the major findings. The State officials were asked if they agreed that dread disease policies have limited economic value and if they would go so far as to charge that such policies were close to being a worthless product. They were asked if they found that fear tactics were employed in the sale of dread disease insurance and whether they had fined or disciplined any insurance companies in conjunction with the sale of dread disease policies. Finally, they were asked if, in general terms, a person would be better off improving his or her existing coverage rather than buying a limited disease policy. (A copy of the questionnaire can be found in Appendix I of this report.)

The Committee's questionnaire which was sent out on December 6, 1978, also served to follow-up on allegations of the shortcomings of cancer insurance policies raised in testimony before the Committee on November 28, 1978. Upon learning of the Committee's questionnaire, American Family Life Assurance Company took the unusual step of writing to every State insurance commissioner on December 15, 1978 with respect to the Committee's inquiry. Company chairman, John Amos, disavowed any attempt to influence the way that Commissioners responded to the Committee. He asked the commissioners to keep an open mind and for the opportunity "to make a factual showing" before the commissioners responded to the questionnaire which he charged was "obviously designed to evoke a negative response." Several commissioners apparently waited for Amos' information before answering. However, by June 1979, most of the States had responded. Follow-up questionnaires and finally, telephone calls followed in order that the views of all 50 commissioners might be recorded on this important issue.

The results of the questionnaire are detailed below, followed by selective comments by State insurance commissioners as well as a summary of the most extensive State investigation of cancer insurance ever undertaken as reported by the Massachusetts Department of Insurance.

### RESULTS OF THE STUDY

Four States,<sup>1</sup> New York, New Jersey, Connecticut and New Hampshire reported that they had an outright ban on the sale of cancer and

<sup>1</sup> The fifth State to ban cancer insurance was Massachusetts in September 1979.

other dread disease policies. Several other States such as Massachusetts, North Carolina and the District of Columbia reported considering such a ban. Eight additional States reported regulations which, in effect, banned cancer policies. These States reported having minimum loss ratio requirements either in law or regulation. These States noted that very few companies selling cancer or other dread disease insurance could meet a loss ratio of 60 percent.

*Accepting the limitations of the questionnaire, over half of the nation's insurance commissioners said that dread disease policies have very limited economic benefit.* Fourteen officials, or 28 percent, disagreed while the remaining 20 percent said they were simply unsure.

Only 20 percent of all commissioners would go on the record as saying flatly that dread disease policies are close to being a worthless product. Most commissioners qualified their answers to the effect that it is possible to write a cancer insurance policy which provides decent coverage for a reasonable fee and which returns 80 or 90 percent of premiums back to the insured in the form of claims. It is possible they said, but it almost never happens in the current market.

*Asked if they had found that insurance companies employ fear tactics in the sale of cancer and dread disease insurance, an amazing 72 percent or 36 commissioners answered in the affirmative.*<sup>2</sup> Six commissioners, or 12 percent answered in the negative. The remaining 16 percent were unsure.

*Asked if they would agree that people are better off improving their existing comprehensive health insurance policy instead of buying a single disease policy, 35 commissioners or 70 percent answered in the affirmative.* Only 5 commissioners or 10 percent of the total disagreed, the remainder were unsure.

Asked if they had ever reprimanded a company or its agents in conjunction with the sale of dread disease policies, 30 percent of all commissioners answered "yes."

Tables with more detailed State by State breakdowns showing the results of the Committee's questionnaire are found at the end of this section.

#### COMMENTS FROM THE STATES

State insurance commissioners were very generous with their comments. Some of them indicated that dread disease insurance, particularly cancer policies, was the most important issue they were presently facing. The States of Massachusetts, California, Delaware, South Carolina and the District of Columbia indicated that they had major studies underway. Others responded that cancer and related dread disease products were a very unimportant issue in the scheme of things. Finally, some commissioners took the opportunity to castigate the Congress for the shortcomings and year-to-year restriction of the Medicare program, which, they asserted, makes possible abuses in the sale of Medicare supplementary health insurance policies of all kinds, including cancer and related dread disease policies. Excerpts from these letters follow.

<sup>2</sup> The commissioners of Puerto Rico and the District of Columbia are not counted in this tally though they answered affirmatively.

## ARKANSAS

The Department responded that dread disease insurance may have value as long as its limited nature is understood by the purchaser. "(The policies) are designed to supplement other coverage and this fact must be prominently displayed on all policies sold in Arkansas."

## CONNECTICUT

The Department provided the information that the State bars the sale of dread disease policies which it agreed were close to being a worthless product. The Department's ban followed an act of the Connecticut legislature which took effect in 1976. According to Mr. John Sansone, the principal examiner for the Department, a variety of reasons led to the law.

First, Mr. Sansone pointed out that he felt such policies do not provide the dollar value for premiums paid by the policyholder. He mentioned that such policies highlight their benefits as having maximum limits of \$50,000, \$100,000 or in some instances there is no limit on the maximum benefit. He said, "The nitty-gritty of the situation is, however, that the average hospital stay is only about 7 days, and that it would literally take 3 years to collect these maximum benefits." Furthermore, he continued, "In Connecticut they had companies who were paying out only 30 percent of the premiums collected on these dread disease policies. And in some instances even less. Elderly, who are on medicare, do not need this policy. They were better off if they beefed up their hospital and medical insurance to cover expenses of all their health problems."

Second, Mr. Sansone indicated that there were problems associated with the sale of a "cancer-only" policy. Many do not understand that it will pay for cancer only, and not for the complications of cancer. If while you are in the hospital receiving treatment for cancer, and cancer complicates other parts of the body, the company may refuse to pay benefits arguing that such payments cannot be paid for conditions other than cancer. Mr. Sansone added, "By its very nature, cancer complicates many parts of the body." A cancer-only policy can be compromised in many other interesting ways, according to Mr. Sansone. He gave the example of an individual who was covered by a cancer policy. He was a diabetic when he took out the policy, and did eventually contract cancer which required a 10-day hospital stay. The company involved refused to pay for more than 4 days of the hospital stay—arguing that the policyholder might not have been in the hospital more than 4 days if he were not a diabetic. Persons who find themselves in this situation have very little recourse. The cost to litigate is too costly for the \$300 claim involved.

Mr. Sansone also expressed concern regarding the manner in which these policies were sold. He mentioned that there were problems involved with the fear tactics used and cited examples of agents using the names of famous people who had been stricken with the specific disease. "Oftentimes, people felt they were insuring themselves against cancer when they bought the policy. In fact, when the policies were banned in the State, the biggest complainers were not the companies, but the agents and in some instances, the people themselves. They

would call the insurance company and ask them why they didn't let them make up their own mind about what they wanted to buy." Sansone added, "Here you are trying to protect people, and they won't accept that kind of assistance—they want to make their own decisions about what is best for them."

#### COLORADO

The Colorado Department said that "a cancer only or specified disease policy is both sold and purchased on a fear or scare basis. However, it is frequently advisable to buy such additional coverage as a rider or supplement to an existing policy."

#### GEORGIA

The commissioner commented :

[T]hose people who have comprehensive coverage already, no doubt, would be better off if they improve their existing coverage. However, most people who have comprehensive coverage are covered by group insurance and do not have the privilege of improving their comprehensive coverage as an individual because it would require the entire group to improve the comprehensive coverage in that there is no individual underwriting in group insurance . . . Therefore, I believe that the insurance buying public should have the freedom to choose the coverage they desire as long as they know what they are getting and are not misled.

#### ILLINOIS

The Illinois Department of Insurance had the following to report to the Consumer Union regarding the sale of cancer insurance :

We can't find a legal basis for banning it, said Lloyd Rice, Assistant Deputy Director of the Illinois Department of Insurance. (Pennsylvania's insurance department had tried to ban such sales but lost in a court test). I think it might smack of restraint of trade. We do review each and every cancer contract received in this office. Rice said he was fairly certain the department would object to any cancer policy that excludes coverage of complications caused by cancer therapy. However, Illinois permits the sale of the Union Fidelity policy, which has just that exclusion.

#### INDIANA

After responding that dread disease policies do have economic benefit, the Indiana commissioner penned a comment which implies the opposite answer. He said the policies have "limited economic value in most instances, however, they are a good buy, if, in fact, the individual has cancer, etc. (although) it is true that very few people ever use the policy."

## KANSAS

The Kansas commissioner offered numerous examples where his department had taken action against cancer insurers because of deceptive or misleading claims. In one 1973 example, the Old American Insurance Company was fined for advertising that "for only \$1.00 you can protect your entire family for 90 days against the mounting cost of cancer." Unfortunately, the benefits provided under the policy provided for hospitalization due to cancer to begin 60 days from the policy's effective date—a total elapsed time of about 90 days. According to the cease and desist order filed in the case, the company was asserting that both the insured and the spouse would be covered, when, in fact, only single coverage is provided.

With respect to the questionnaire the commissioner said :

[I]f a dread disease policy is viewed purely from an economic standpoint and with a recognition that insurance covering a specified disease is a "long shot" at best, one could easily conclude that it is a worthless product. On the other hand, if a person has a particular concern about the potential economic consequences of a given disease, the limited nature of the coverage is fairly and accurately disclosed and the individual gains a real sense of security from its purchase, then one should not conclude that it is a worthless product. Similarly, it is reasonable to assume that most people would be better off if they improved their comprehensive coverage yet specified disease policies do permit individuals to address a particular concern and gives them some flexibility as to the way they do so. Thus, while you or I might not purchase a specific disease policy ourselves, other people might have a different judgment or different motives.

## KENTUCKY

The commissioner said "we do not agree that cancer insurance is close to being a worthless product; however, if you use the words dread disease as an all encompassing statement, the answer may be yes."

## MAINE

The Maine Commissioner said there were few problems with cancer insurance in his State. He was the only commissioner to object to the way the questions were framed in the questionnaire. "Perhaps if the questions were framed in a more objective manner we could answer 'yes' or 'no,' saving time for both of us," he said.

## MARYLAND

"While I agree that it is better for a person to buy health insurance coverage for all types of illnesses, I cannot agree that cancer policies have no worth," said the commissioner. "Even though such policies may not cover costs in full, they do provide some assistance in payment of hospital costs which may run to considerable amounts in some types of cancer."

"This is particularly true in the case of leukemia where hospitalization may be required for very long periods, sometimes beyond the period which is covered by the patient's basic hospital insurance. Consequently, I do not believe that the public should be denied the opportunity to purchase this type of insurance provided the premium charge is fair and the purchaser understands the type of coverage being provided."

#### MASSACHUSETTS

See page 154 for a summary of the Massachusetts response.

#### MICHIGAN

The Department has a very negative view of cancer and related dread disease policies. The commissioner agreed that the policies had little economic benefit. He said they were close to being a worthless product, particularly "as contrasted to the comprehensive health coverage which an insurance dollar could be used to purchase." He added :

Dread-disease policies receive close regulatory scrutiny and must conform to special rules. For example, dread disease policies sold by commercial insurers on an individual basis to the medicare eligible must attain a minimum anticipated loss ratio of 65%. Specific advertising rules prohibit the use of language designed to create fear or anxiety on the part of the prospective insured.

The most insidious problem which a regulator must confront in the dread disease market is agent practices. It is difficult to actually monitor the tactics used by agents in the field. For enforcement activities in these cases, the Insurance Bureau generally must rely on complaints from individuals to detect a pattern of misconduct. If only one complaint is lodged, the case often reduces to a one-on-one situation, the elderly person's word against the agent's. When this occurs, it is difficult for the Insurance Bureau to take any action.

#### MINNESOTA

The Department was reluctant to comment in general on the economic benefit of dread disease policies. However, they did provide evidence that the issue has caused problems in the State. "We have criticized the following companies relative to their advertising of cancer insurance policies in Minnesota :"

Company	Date
American Family Life Assurance-----	September 1971.
Lone Star Life Insurance Co-----	October 1971.
ITT Life Insurance Co-----	July 1973.
Reliable Life and Casualty Co-----	May 1975.
Great Commonwealth Life Insurance Co-----	August 1975.
Union Fidelity Life Insurance Co-----	May 1978.
Guarantee Trust Life Insurance Co-----	October 1978.

#### MISSISSIPPI

The commissioner said that he felt that American Family Life Assurance Company had been "unfairly castigated" by the June 1978

*Consumer Reports* article. He said the company is licensed in his State and, for the most part, consumers appear to be satisfied with the company. "Many of the employees of the Mississippi Insurance Department have a cancer policy with American Family," he added, noting that since 1964, "five employees of the Department had contracted cancer, two of which were terminal. All claims handled by American Family were handled to the utmost satisfaction of the employee and their family."

However, after this testimonial the commissioner added :

I am convinced that there are some shortcomings with this type of insurance, such as the following: (1) The type test required before cancer can be diagnosed and the manner in which this is explained to the insured; (2) High amounts or unlimited total values of policies sometimes being used as a gimmick to sell the policy; (3) Some policies state that payment must be for the treatment of cancer. This is impossible with some terminal cases when the last visits to the hospital are actually just keeping the patient comfortable and not for treatment.

#### NEVADA

An official with the Department had this comment :

The specialized policy such as the cancer policy is a limited benefit policy as is the accident only policy. The cancer policy is a supplement to other coverage one might have and I have found through discussions with the elderly that the emotional security some of them feel having this extra coverage is far from worthless.

#### NEW HAMPSHIRE

The Commissioner responded saying that the Department "does not allow the sale of dread disease policies" in the State for reasons spelled out in a 1972 memo reproduced in Section III of this report.

#### NEW JERSEY

The Consumer Union reported that New Jersey, at one time, permitted the sale of dread disease riders while banning separate policies. However, after government statistics revealed that New Jersey was a State most heavily affected by cancer, a number of companies printed "tail wagging the dog" advertisements promoting their cancer coverage while mentioning, less prominently, that it was attached to a general health insurance policy. In other words, companies were supplementing their cancer policies with general policies which was not what the New Jersey department of insurance had intended. Therefore, the department announced, in 1976, that it would no longer approve any dread disease policies or riders.<sup>1</sup>

<sup>1</sup> Dread disease policies were banned in New Jersey on the basis of the following statute (NJSA 17B:26-1(8)), which states:

The disapproval by the commissioner of any such form may be on the ground that:

- (1) the benefits are unreasonable in relation to the premium charged, or
- (2) such form contains provisions which are unjust, unfair, inequitable, misleading, contrary to law or to the public policy of this State, or
- (3) the policy is sold in such a manner as to mislead the insured, or
- (4) insurance under such policy is being solicited by means of advertising, communication or dissemination of information which involved misleading or inadequate description of the provisions of the policy, specifying particulars.

The commissioner confirmed for the Committee that he imposed the complete ban because dread disease policies are "of limited value and generally sold in a misleading manner."

The Committee staff contacted the New Jersey department of insurance to further explore the problems encountered by the State with regulating the sale of dread disease policies. An actuary with the New Jersey insurance department explained that such policies can mislead consumers. "Many consumers," she said, "were led to believe that dread disease policies were sufficient coverage for all their future health problems and dropped their general insurance policies."

#### NEW MEXICO

The insurance department also has a very negative view of dread disease insurance, agreeing that it is close to being a worthless product. The commissioner added these comments:

Some problems experienced by the State of New Mexico in the solicitation of dread disease policies are coordination of benefits with an individual policy or a group accident and health policy, high pressured salesmen selling dread disease policies, and paying of claims when the insured did not fully disclose true medical history, thus the insurance company underwrites the policy at the time of a loss rather than at the time of the issuance of the policy.

#### NEW YORK

The superintendent of insurance told the Committee that the State has had strong reservations about dread disease policies for years. He cited the limited economic benefit, and the fact that many people were dropping their regular health coverage with the belief that dread disease coverage was sufficient to meet their needs, as two reasons why the sale of such policies is barred in the State.

The department of insurance put the ban in effect by regulation in 1971 saying:

No policy shall provide benefits for specified disease, or for procedures or treatments unique to specified diseases, and no policy shall provide additional benefits for such specified diseases or procedures unless the policy also provides (broad-based accident and health insurance protection) insurance which meets the definition contained in sections 52.5, 52.6, or 52.7 of this part.

New York also bans cancer insurance by virtue of another regulation which requires that insurance companies return at least 60 cents on the premium dollar back to their insured in the form of claims. As noted, few cancer insurance firms can meet that standard. Since 1971, the Department has been convinced that the sales and administrative expenses of such policies were unduly large.

The department also found that specified dread disease coverage tended to lead to wasteful arguments over what disease the patient actually had. New York does permit companies to tack dread-disease

riders onto comprehensive health insurance policies. But, according to the New York insurance department examiner, such policies have to meet strict standards.

As far back as February 27, 1972, Malcolm MacKay, deputy superintendent of insurance for New York stated to the *New York Times*:

The worst abuse in commercial health insurance in New York involved the sale of "dread-disease" policies; for example, those that provide cash payments if the beneficiary develops cancer.

#### NORTH CAROLINA

The Department indicated that it had found problems with dread-disease insurance noting that:

The vast majority of them stem from the individual performance of the agent. . . . We have also found that the complaints are sporadic, rising as sales teams work certain areas and elect to take virtually all steps to gain access to the homes of prospects—from representing themselves as being from the "government" to representing the American Cancer Society.

The elderly citizen of North Carolina, like others, is often living in a "syndrome of fear," and regardless of warnings from families, friends, this office and those who attend to their needs, are still prone to admit aggressive agents and reluctant to take a position of resistance as a younger person might adopt, which makes them easy prey for the unscrupulous agent.

The spokesman for the department said they had considered and rejected a ban on door-to-door sales of cancer and related single disease policies as well as mail order offerings, deciding instead to redouble their enforcement efforts.

#### NORTH DAKOTA

The commissioner said:

Cancer policies are expensive when looking at them from the loss ratio point of view. Companies that sell cancer policies, exclusively, return only 20-25% in North Dakota, in some cases. These companies have the lowest loss ratios of any health insurance companies in the State.

Cancer policies, it is true, are often sold on a "fear basis". . . .

Is cancer insurance a worthless product? Cancer coverage is a gamble. It is a long shot gamble, but, if someone contracts cancer, cancer coverage could be very valuable to them in the form of loss of time payments and to pay for extra expenses which often develop where long distances to treatment centers require considerable travel. Likely, it is true that *most* people would be better off improving comprehensive coverage than buying a cancer policy, but some cases can be conceived in which people would have superior coverage under a cancer policy than under a more expensive comprehensive plan.

## OHIO

The Department's view can be summarized as "let the buyer beware." "The individual is responsible for his or her own buying decisions," commented the commissioner, who added, "the marketplace is the best regulator of the business of insurance."

Unless the legislature desires to make a decision as to the offering of certain limited policies, the policies are for sale in Ohio and their economic value will be reflected in their ability to be sold. Apparently in Ohio individuals desire to purchase cancer insurance and have purchased cancer insurance policies. Additionally, the companies who provide said coverages have made payments based on those contracts. The ultimate buying decision should rest with the consuming public and the Department does not believe it should be editorializing as to a product which State statutes have not prohibited.

## PENNSYLVANIA

The Department said it issued a regulation banning the sale of cancer insurance in 1972. However, American Family Life Assurance (AFLAC) brought suit charging that the commissioner did not have power to ban policies meeting the technical requirements of Pennsylvania insurance laws. The Court agreed with AFLAC.

The Commissioner said that cancer insurance is tightly regulated because such policies are close to a worthless product. He added that the department would favor enactment of legislation barring cancer insurance "because our opinion of cancer insurance policies has never changed."

## RHODE ISLAND

In response to a July 1978 questionnaire to all State insurance commissioners, Rhode Island offered that dread disease policies constituted the number one problem presently before the Department. In response to the more recent questionnaire, the commissioner said that Rhode Island indirectly bars the sale of cancer insurance. Rhode Island has a minimum benefit regulation which requires that an insurer return at least 50 percent of premiums back to their insured in the form of claims. Few policies can meet this standard at present, he suggested. He added that the principal motivation of cancer—or any insurance—is fear.

Rhode Island passed, in 1974, a catastrophic health insurance plan, referred to as the CHIP Act. The purpose of this act is to assure that each person residing in the State of Rhode Island has access to needed health services at reasonable costs. The Rhode Island department of health administers this act with the cooperation of the State department of insurance. The Committee has been advised that the Rhode Island department of health will propose in the next assembly that dread disease policies, primarily cancer policies, be banned for sale in the State of Rhode Island. The health department will use the CHIP Act as the basis for this proposal.

## UTAH

The Department responded :

The position of this department is that while we may not believe that specified disease or "dread disease" policies as a purchase constitute a wise economic decision, we do maintain that the public purchasing this product is entitled to make that decision. We agree that this product may be oversold and that fear tactics may be used by unprofessional agents. It should be noted that this product is sold not only to the senior community but the community at large, as well.

## VERMONT

The Vermont commissioner provided the Committee with a great deal of information about the abhorrent practices of some companies which specialize in the mail order sale of cancer insurance. See Section VII of this report.

## VIRGINIA

The commissioner indicated that he was greatly concerned about the case made against dread disease insurance in *Consumer Reports*. He implied agreement with most of the charges but said he did not feel banning of the product was the appropriate action to take. Instead he reported that he had requested that the legislature give his department the authority to regulate health insurance rates. The point is that the commissioner could step in and make sure that all products were appropriately priced and would provide reasonable economic benefit to the consumer. Not one State insurance department indicated that it had the authority to set rates for health insurance.

## WASHINGTON

A Washington department of insurance official also expressed concern regarding the sale of dread disease policies in the State of Washington. "The coverage or benefits provided by dread disease policies," the official commented, "appear to be extremely limited. These policies merit a closer look."

This same official reported that the limitations and exclusions in cancer policies are bothersome. One critical problem the department has encountered was with respect to the requirement that a biopsy by a pathologist, not merely confirmation by the physician, is necessary before coverage can become effective. He said that "in some cases, individuals are so far gone with cancer that a biopsy is unnecessary. Unfortunately, for the person without the biopsy by a pathologist, coverage is not required." The commissioner said he once asked that the body of a deceased cancer victim be exhumed, and that a pathology report be filed, in order that payment could be made to the person's estate.

## WEST VIRGINIA/WISCONSIN

The insurance commissioners of these two States share the negative view of cancer/dread disease insurance as expressed by such States as

New York, Connecticut, New Jersey, Michigan and Pennsylvania. They answered that such policies have limited economic value and are close to being a worthless product. The State of West Virginia reported on-going litigation against two cancer insurers.

AN IN-DEPTH INVESTIGATION OF CANCER INSURANCE :  
MASSACHUSETTS

The State of Massachusetts also has a very negative view of cancer and related dread disease insurance. The State's view is not based simply on past experience and complaints, but on the basis of the most objective and comprehensive State investigation of cancer insurance ever undertaken. The excellent report, prepared by Lindalee Lawrence and James Klopper of the Department's Research and Education Staff, is entitled simply: "A Study of Cancer Insurance." This report, summarized below, is considered by insurance experts to be the most impressive undertaking of its kind in the cancer/dread disease insurance field.

MAJOR POINTS OF THE STUDY

*1. Use of Fear Tactics*

The Massachusetts Insurance Department came to the firm conclusion that cancer/dread disease merchants create a climate of fear in order to sell their policies. The Department found a good deal of "skeleton rattling" by companies in this field:

The Division of Insurance found a pattern of selling that depends essentially on evoking fears about this disease. In truth, the lowest common denominator of all cancer insurance selling is the unabashed campaign to inform all consumers why, if they are not already scared to death of cancer, they unquestionably should be.

The report mentions the use of graphics depicting "a gnarled and menacing growth, identified as 'cancerous tissue' spreading across a scarlet background and the names of celebrities in white type on a 'funereal black background' pointing to a warning: "The same thing that happened to them could happen to you.'"

In response to the rebuttal from cancer insurers that all insurance purchases are motivated by fear, the report says:

It is clear, however, that the cultivation of fear plays so large a role in regard to no other insurance product. Automobile accidents occur more frequently than cancer, and can cause either death or painful and permanent disability; but auto insurance agents do not usually recite the grim statistics of accident carnage to sell policies. Heart disease kills more people than cancer, and costs more; but companies selling basic health insurance (which covers heart disease and nearly all other illnesses) do not ordinarily compete for business through statistical polemics alleging the prime importance of that disease.

*2. Implying Endorsement from the American Cancer Society*

The report notes that some insurers mention the American Cancer Society in the advertising as many times as their own name. The pur-

pose, says the report, is to imply that the American Cancer Society endorses their product. The society does not endorse cancer insurance policies.

### *3. Exaggerating Statistics*

Cancer insurers assert that 1 out of every 4 people will contract cancer and that cancer is on the increase. The report points out that the overall incidence of cancer has decreased slightly in the last 25 years. The often-quoted assertion that "one out of four Americans will be stricken by cancer," the report says, "could lead to the erroneous conclusion that one-quarter of the population now has cancer." The facts are that one out of every 280 Americans will contract cancer. Even this 1 in 280 figure can be misleading, says the report:

To make an informed assessment, a consumer might want to know that the incidence of cancer varies greatly by age and community. Because some cancers are preventable, lower rates of incidence also apply to persons who avoid known causes of cancer, such as cigarette smoking; it is estimated that smoking alone accounts for 80% of all cases of lung cancer, or more than 10% of all cases of cancer. In addition, a consumer might want to know that overall cancer-incidence estimates include many types of cancer, which are not all equally severe or costly. Colon cancer, for example, is highly curable (and therefore relatively less costly) if detected early; and colon cancer accounts for an estimated 15% of all new cancer cases.

### *4. Belaboring Cancer Costs*

The report notes that cancer insurers overstate the cost of cancer both to the society in general and to individuals who develop the disease. Companies assert that the average cost of treatment is between \$20,000 and \$40,000 for an individual and something like \$5 billion for the nation in general. The report says:

Like the statistical presentations used to demonstrate the high incidence of cancer, the company pronouncements on cancer costs are objectionable on several grounds. Adjectives like "crushing," "smothering," "staggering," and "astronomical" are obviously calculated to alarm without informing the consumer, and vague references to the possibility of bankruptcy for cancer victims likewise provide no quantifiable measure of the likelihood or extent of catastrophic loss.

The report notes that there are very few reliable studies for either the societal or individual cancer costs. The best information available to the Massachusetts department is that long-term cancer patients with serious cancer strains faced an average cost of \$10,000.

### *5. Belittling Basic Health Insurance*

The report makes the point that cancer insurers belittle existing policies. They imply falsely that existing comprehensive policies will be of little use if an individual develops cancer. Basic health plans will provide significant protection for most people, asserts the report:

(Cancer policies and advertisements) obscure the fact that many conventional health insurance policies will indeed pay for most or all of the costs of medical care for cancer.

If this conventional health insurance policy performs even moderately well, it will relieve the consumer's cancer policy of any necessity to deliver on its claim to be a major source of cancer compensation. If the conventional policy provides broad cancer coverage—as many do—it will relieve the cancer policy of any serious pressure to perform effectively even as a supplement.

The report charges that American Family Life Assurance has a policy of denigrating basic coverage because such policies pay doctors and hospitals directly, "in reality you do not have any insurance. You just pay high premiums," is a false, malicious, and patently absurd statement, says the department.

#### *6. Illusory Promises of Peace of Mind*

The report charges that cancer insurers offer a "grim recital of cancer risks . . . then focus to a proffered happy ending: the purchase of a cancer insurance policy. If cancer insurance is overblown, so is the nature of the remedy." The report adds that cancer insurers skillfully "play upon the consumer's desire for peace of mind." It says that companies promising \$200,000 or \$250,000 in protection against cancer and by dramatizing such maximum dollar benefits "ingeniously quantify the abstract essence of peace of mind and imply a virtually inexhaustible source of financial protection against cancer." Putting their case another way, some firms advertise benefits up to \$6,000 a month with no lifetime limit. However, what the unwary consumer does not know is that 92 percent of the proffered \$200,000 or \$250,000 (lesser increments are available) becomes available only after a cancer patient has been hospitalized continuously for 90 days and thus becomes eligible for what the policies term "extended hospital benefits." The report notes that to collect the \$200,000 Union Fidelity offers in its plan, the cancer victim would have to be hospitalized continuously for 652 days or nearly 22 months.

The report comments:

Since the average hospital stay for cancer is less than 16 days, and since more than 99% of cancer patients have hospital stays of less than 90 days, it is highly unlikely that most cancer victims will ever use any part of the extended hospital benefits provided by various policies. . . .

The relatively small worth of any coverage for a hospitalization of more than 90 days is reflected in the fact that only about 0.1% of claim dollars—one dollar out of each thousand—is paid out under this policy provision.

The report says that companies use these misleading figures (i.e. the promise of \$200,000 in coverage) "to puff-up—at practically no cost—the attractiveness of their product to sales prospects." It adds:

[I]t is likely that most consumers receive an exaggerated, highly unrealistic impression of the practical performance of cancer insurance. And a very illusory foundation for Peace of Mind.

### 7. *Promising Much, Delivering Little*

The Massachusetts Department found that cancer policies “promised a mountain range of benefits but provided molehills of actual compensation.”

[N]o insurance policy functions more truly like a sieve than cancer coverage. Subtly, unobtrusively, but systematically and effectively, the myriad limitations of cancer insurance riddle the policy with holes that drop out about 70% of cancer costs, leaving them to be paid by the cancer victim—or his conventional health insurance plan.

Despite its expansive promises of “peace of mind” for cancer victims, American Family paid total benefits averaging only \$1,278 per successful claimant during the 18-month period between January 1, 1977 and June 30, 1978.

Despite policies called “the \$200,000 Plan” and the “\$150,000 Plan,” Union Fidelity paid benefits averaging only \$1,406 per claimant during a similar period.

Despite stern warnings of “staggering . . . astronomical” cancer costs running to “between \$30–\$40,000 per cancer victim,” American Income’s average claim payment totaled only \$1,397 during a comparable time.

Creative in exploiting the fears and winning the confidence of consumers regarding a way to fill the need for cancer compensation, cancer insurers are, however, more resourceful in finding the means to reject or reduce cancer claims than in finding the willingness or the ability to pay them.

### 8. *The Big Print Gives It To You But The Little Print Takes It Away*

The report is explicit on this point :

[T]he real genius of cancer policies—their ability to suggest broad coverage while providing at every turn for the narrowing of benefit payments—is a constitutional trait that runs much deeper than policy language . . .

On closer examination, it may be more clearly discerned that every cancer insurance benefit provision is simultaneously an act of giving and an act of taking away. Useful for suggesting broad and varied coverage, the cancer policy’s separate listing of numerous specific benefits also creates the opportunity to impose separate benefit ‘limits’ that are specific and severe.

The typical policy pays for private duty nursing in the hospital, for example, but only to a limit of \$24 per day with a lifetime limit of \$600. The typical policy covers radiation therapy in or out of the hospital, but only “up to” a lifetime limit of \$1,000. The policy pays for hospital room and board, but only to a limit of \$60 per day for the first seven days and \$30 per day for the next 83 days.

### 9. *Uncommon Restrictions*

The report charges that cancer insurance resorts to the use of numerous restrictions and limitations which are uncommonly harsh even

when judged against the most outrageous practices in other aspects of the insurance industry. The report offers the example of policies that have waiting periods during which the insurance company is not obligated to pay claims. These waiting periods are commonly 60 to 90 days—sometimes more. In general terms, coverage is excluded for diseases or problems arising during the 60 or 90 day period but are covered thereafter. In the cancer insurance practice, if the disease is diagnosed during the term of the waiting period, the company is excused from coverage not only for the term of the waiting period but permanently.

The small print in most cancer policies limits coverage to “definitive cancer costs.” This phrase means there will be no coverage for cancer *diagnosis* or for health problems caused or complicated by cancer and cancer treatment or for therapy and rehabilitation.

Another classic example involves the use of a confusing, 167-word sentence by one cancer insurer to describe benefits and exclusions under its policy. Says the report:

[T]he dramatic accents in which they often present their version of policy benefits, cancer insurers also know how to be subtle, indirect and occasionally inscrutable in their discussion of policy limitations. Usually collapsed into a single paragraph away from the glare of large-type headlines, color ink and graphic displays lavished on policy benefits and cancer statistics, the list of limitations receives much less emphasis and explanation than it deserves.

Uncommonly restrictive “waiting periods,” the restriction of benefits to “definitive cancer treatment,” and the fundamental design of cancer insurance as supplemental—and fragmentary—coverage are among the important limitations of cancer policies that are systematically minimized or ignored in many marketing materials and sales presentations.

The report concludes that cancer insurers are masters in the use of “obtuse legal jargon” and “circumlocution.” Examples of purposely confusing, obfuscating language are offered in the report and labeled “explicitly deceptive.”

The report says:

In practice, however, cancer insurance policies are effectively designed to do through over-complication what the selling presentations do through oversimplification: simultaneously to exaggerate and obfuscate the real performance of cancer coverage.

It is the uncommon restrictiveness of some of these limitations—and above all, the unexpected placement of so many holes, ditches and fences in a terrain where the billboards soothingly proclaim “Peace of Mind,” “the \$200,000 Plan,” and unlimited extended benefits—that make them so unfair.

#### 10. *Cancer Policies are Hospital Oriented*

The report notes that most policies are geared to pay for cancer costs when the individual is in a hospital:

The typical cancer policy covers very few of the out-patient costs of cancer patients, even though for some patients these costs may be greater than the cost of inpatient

care—and even though these costs are the least well covered by some conventional health insurance policies. None of the six cancer policies examined by the Division covers drugs outside the hospital, home nursing, physical therapy, special equipment, prosthetics, or nursing home care.

While most all policies pay for radiation therapy, it is common for coverage to be limited to \$1,000 maximum which would be reached fairly quickly by a patient undergoing this kind of therapy. After the limit is reached, the policy is of no value. Interestingly, the report notes that only one policy of the six major national plans it examined had coverage for chemotherapy.

#### *11. Non-Payment Until Cancer Is Diagnosed Pathologically*

Says the report:

The typical cancer policy pays benefits only if cancer is diagnosed pathologically; clinical diagnosis is not acceptable. This distinction may seem of little consequence, but it is not without serious problems, as noted by one physician writing to protest the denial of his patient's claim:

"We therefore felt he has clinical evidence of lung cancer with a brain metastasis . . . if he succumbs, we will get (a pathological report) in autopsy and if his condition goes on to further deterioration we then can perhaps operate and get a tissue diagnosis to prove it, but I would consider this unnecessary surgery."

For a variety of reasons having to do with the age and health of the patient and the type of cancer involved, a pathological diagnosis is not always medically necessary, desirable, or possible. Lung cancer and brain cancer are two types of the disease in which cytological washings, CAT scanning and other diagnostic procedures are often used as a substitute for the surgical removal of a tissue sample.

#### *12. Time Limits on Payment*

Many cancer policyholders have no idea that their coverage is subject, in some cases, to severe time limits:

Three of the six cancer policies reviewed by the Division of Insurance will pay benefits only within a specified time limit—usually three years—after the date of cancer diagnosis. Although three years may seem an adequate time in which to treat cancer, a number of cancers involve treatment of longer duration. This may be inferred from median survival times, which represent the length of time after cancer diagnosis when half the patients have died and half are still alive.

For breast cancer, for example, the median survival time is six years and seven months. Of the 50% of patients who die within this time, a sizeable number undoubtedly die after three years from the date of diagnosis, and if they had cancer insurance, they would not have had their treatment before death covered. The 50% of patients who live longer than the median survival time would face an even longer period of potential costs without the continuing protection of cancer insurance benefits.

*13. Cancer Policies by Definition Won't Pay for Any Illness or Injury Other Than Cancer and They Pay Less of Cancer Costs Than Advertised*

From their advertising, consumers could well get the impression that cancer insurance policies cover a wealth of health-related expenses. Not so, says the report:

Against the backdrop of sweeping selling claims, the Division has traced product limitations that do not fulfill even the most modest expectations a consumer might apply to any insurance policy. Against the narrower, specific claim of cancer coverage to be a valuable insurance supplement, narrower and more specific defects have been revealed.

After making the point that the policies only cover pathologically confirmed cancer, the report adds:

Despite its costliness, cancer is not the only expensive health problem for which consumers must try to obtain adequate insurance protection. Cancer in fact accounts for only 5% of total medical costs, and a cancer policy accordingly provides protection for about 30% of that amount, or 1.5% of total medical costs.

The report also refers to a claim by American Family Life Assurance that it will pay "50 percent of the cost of care and treatment for cancer," and adds:

Contrary to the expectation created by this statement, however, a Price-Waterhouse audit for the Division of Insurance has determined that for a representative sample of Massachusetts insureds, American Family actually paid only 23.4% of submitted cancer costs.

In general terms the Department concluded:

[I]t appears that the typical cancer policy covers only about 30% of total cancer costs. This percentage further erodes over time because of the effect of inflation on fixed benefit limits. As it does, the actual performance of cancer insurance contrasts all the more dramatically with the leading cancer insurer's widely publicized intention to pay 50% of total cancer costs.

*14. Limited Economic Value*

The report charges that cancer policies have very limited economic value:

If cancer claims were as large and as common as cancer insurers suggest, and if cancer policies delivered the sweeping benefits that their selling presentations imply, one would expect the loss ratios for such policies to be relatively high. Quite the contrary is true, however.

Union Fidelity's cancer policies, for example, generated a collective loss ratio of 23.4% for business written in Massachusetts between 1975 and 1978. Similarly, American In-

come's two major cancer policies showed a loss ratio of approximately 25% during the period January 1976 through September 1978. Between January 1977 and July 1978, American Family's cancer policies showed an incurred loss ratio of 42.5%. But the three most popular American Family cancer plans, which account for more than 70% of its cancer premiums in Massachusetts, showed an incurred loss ratio of 33.2% during the same period.

For the large number of cancer insurance policyholders who keep their policies only one or several years, however, the gradual increase in loss ratios is one more example of a benefit more illusory than real.

Among a national group of consumers who bought American Family policies in 1975, for example, the Division of Insurance has examined the rate of lapsation (the percentage that dropped their policies at one-year intervals) compared with the gradual increase in loss ratios over time.

In 1975, the year of issue, the loss ratio applicable to this group of policyholders was 10%. Thereafter it increased at one-year intervals to 31%, 44%, and, for the fifth year, to 52%.

Only about half of the original group of policyholders kept their policies at least to the fifth year, when the policy was paying out 52 cents for each premium dollar collected. For the other half who gave up their policies after four years or less, the American Family policy achieved loss ratios ranging from 10% to 48%. Half this group, or 25% of the original group of policyholders, gave up their coverage after only one year—when the policy was paying 10 cents in benefits for each premium dollar collected.

Even after giving cancer insurers the greatest possible latitude and computing loss ratios over a 30-year period, the Department estimated that American Family's "cancer plans *will pay benefits of 56 cents for each dollar of premiums that the company collects.*" (Emphasis in the original). The report states that there is good reason to believe that the other insurers examined will have an even worse record as indicated by the fact that they pay salesmen 70 percent commissions instead of American Family's 50 percent.

The report adds:

Returning anticipated benefits of no more than 56 cents per premium dollar to all consumers over the 30 years of a policy's lifetime, and returning only 10 to 48 cents on the dollar to the 50% of purchasers who keep their policies four years or less, cancer insurance clearly is no bargain.

After commending American Family for making its data available, the Department decried the lack of data from other firms:

The dearth of company information and analysis on claims payouts as a share of the premium dollar over the short or the long term constitutes one further obstacle to rational

purchase decisions about cancer insurance. The most charitable interpretation of this information gap is that most cancer insurers are not interested in encouraging a rational analysis of their policies; a less charitable explanation is that they actively seek to suppress facts whose negative impact would be immediately and palpably clear.

#### *15. Phony Double Recovery Claims*

The report takes exception with the practice of some cancer insurers to appeal to greed, suggesting that they may recover twice if they have both a cancer and a basic health insurance policy. It charges that American Family's "characterization of its policy as a source of double recovery of cancer is probably more blatantly seductive than, and as misleading as, the marketing presentations of insurers that allow a consumer to believe cancer policies are the sole significant source of benefits for cancer costs."

The presentation is seductive because duplicate insurance payments, though attractive when viewed in isolation, contribute to the waste and inefficiency that make health care and health insurance costs a leading contributor to inflation and a pressing concern of families and government.

It is misleading because a consumer's other health insurance may have a "coordination of benefits" provision that will reduce its benefits when a covered service is paid for in whole or in part by American Family's cancer policy.

#### *16. Choreographed Sales Techniques: The Universal Efficacy of the Hard Sell*

The report takes exception to the sales practices employed by agents under the instruction of the cancer insurance companies they work for. The report provides examples of training materials used by several companies designed to put the potential customer on the defensive. Here is an example:

[A]lways have eye contact with your prospect . . . Always nod your head slightly when looking at the prospect . . . When closing, always move in towards the person you're selling. Never back away. The slightest backward movement can lose the sale . . . Even if it seems like he'll never answer just keep eye contact and nod your head slightly. Remember, the first person who talks, loses.

The report adds:

Like all hard-sell businessmen, the dominant cancer insurers wage a continuing battle for sales in which technique, rather than product quality, is often the key to success. To the extent possible, it is a battle in which the winners—and the losers—have been determined in advance.

The genius of the industry's battle plan is that sales prospects are not merely outmaneuvered and outgunned; most hardly notice that the battle was done.

The burden of the plan is that, in the heat of battle, the thin line between enthusiasm and deception is often breached.

*17. Well, What Do You Expect, for \$75 a Year?*

The report notes that when faced with the charges listed above, cancer insurers retreat into their shells claiming that they sell a product which is inexpensive and only designed to provide supplementary coverage. On the question of costs the report says:

Beginning with the assertion that cancer insurance is a low-cost coverage, it is immediately necessary to add that price is not the same as value, and low cost is not necessarily the equivalent of a bargain. Many products that can be bought for a relatively low price may be worthless or almost worthless to the buyer, and very few consumers may want to squander money on a product of dubious value, even if it is available at a relatively modest price.

The report then adds that "real" supplementary health insurance plans which provide coverage for all health care costs, not just cancer, are available at a similar price:

At a price of \$80 a year for an individual or \$160 a year for a family, for example, one commercial insurer offers a catastrophic major medical policy with a deductible of \$7,500—an amount whose benefit equivalent would be provided by many existing basic insurance policies. This catastrophic policy pays 90% of covered medical expenses in excess of the per illness deductible. Benefits are payable for ten years from the time when the deductible is first met; the deductible itself must be met within two years after an illness first manifests itself.

The policy covers inpatient hospital charges for room and board and other services and supplies; inpatient and outpatient fees of surgeons and anesthesiologists; and outpatient services including physician fees, laboratory tests and diagnostic services, radiation therapy, physical therapy, prescription drugs (including chemotherapy) and home care.

SUMMARY OF THE MASSACHUSETTS STUDY

The Department carries the following paragraphs in its summary of the report:

[T]he unusual fear and vulnerability that many consumers feel in the face of cancer risk is routinely exploited for private gain. The Division of Insurance examination of four cancer insurers has documented a calculated, systematic pattern of selling in which cancer risks and costs are distorted or exaggerated; conventional health insurance is ignored or denigrated; and cancer insurance itself is appealingly but misleadingly described.

Such selling excesses are not merely violative of an elementary notion of fair play; they are also apparently violative of numerous statutory and regulatory provisions under Massachusetts law, as the Division's previously released market conduct audit reports have described in some detail.

From the claim to be the indispensable panacea for "astronomical" cancer costs to the claim to be at least a valuable supplementary policy, the diverse and sometimes contradictory representations of cancer insurance must one by one retreat before the advancing frontier of knowledge about how the product actually performs its chosen tasks.

Providing very modest benefits, on average, to supplement the conventional health insurance it habitually ignores or derides, covering cancer costs haphazardly and other health costs not at all, collecting a dollar of premiums to deliver only about fifty cents in benefits, cancer insurance is not the best available health insurance supplement nor even a moderately good supplement in its own right.

Given the present problems of policy design and marketing, it seems no exaggeration to state that insurance regulators have just begun to see the abuse cancer insurance can breed. In light of the analyses presented in this report, it might be obvious that this coverage warrants strict and vigorous regulation.

#### WHAT KIND OF REGULATION?

The report recommends either prohibiting the sale of cancer insurance in Massachusetts or requiring that cancer insurance be sold only as an adjunct to a broader health insurance policy:

[I]f the problems of cancer insurance are perceived to be interrelated parts of an entire pattern of selling and product design that makes little common or economic sense and thrives fundamentally on the exploitation of consumer ignorance, uncertainty and fear about one disease, then a piecemeal regulatory approach might seem little more than a valiant but futile attempt to apply Band-Aids to an open wound. If a regulator believed a single-disease policy had any conceptual validity at all, he might desire to regulate the basic design of the coverage directly and systematically, rather than indirectly and incrementally. He might also wish to assure that the coverage could only be used for its intended supplemental purpose by requiring that it be sold only in conjunction with a broader policy. If he judged that a single-disease policy makes no logical and economic sense at all, he might prefer an outright ban on the sale of the product.

The members of the research and education staff have observed cancer insurance too closely to believe that its varied excesses and shortcomings are discrete, coincidental, entirely inadvertent. Our perception of the interrelated nature of the problems we have documented leads us to recommend either the third or the fourth regulatory options discussed in this chapter—either directly requiring cancer insurance to meet realistic tests for product design and value, and to be sold only as an adjunct to a broader policy; or prohibiting its sale.

In its June 4, 1979 editorial the *Boston Globe* supported the report's conclusion calling for "strict regulation . . . if not outright exclusion" of cancer insurance in the State.

## PUBLIC HEARINGS

In the first week of September, the Massachusetts Department held hearings to determine whether to revoke the licenses or assess other penalties to the four insurers mentioned in the above study. American Family Life Assurance, American Income Life Insurance and Union Fidelity Life Insurance Company were ordered to "show cause why their licenses should not be revoked, fines imposed, other remedies imposed . . . for their misleading marketing and other violations in the sale of various cancer insurance policies." No disposition of those cases has been announced to date.

In a separate action, the Department found that Washington National Life Insurance Company had failed to comply with marketing rules in its past cancer insurance sales in the State. The company no longer sells insurance in the State but was ordered to file any future marketing materials with the Department in advance of sales.

Files on these companies were referred to the Attorney General's Office for possible action.

As noted elsewhere, the State decided to ban single disease policies. Policies can now only be offered if they provide protection against several diseases and accidents. However, regulations bar the sale of such policies to individuals 65 or over.

DREAD DISEASE POLICIES

## STATE COMMISSIONERS RESPONSE TO:

In your experience, have you ever found that companies selling these products employ fear tactics to promote their policies?

<u>STATE</u>	<u>YES</u>	<u>NO</u>	<u>NO COMMENT</u>
Alabama		X	
Alaska	X		
Arizona			X
Arkansas	X*		
California	X*		
Colorado	X		
Connecticut			X
Delaware	X		
Florida	X		
Georgia	X		
Hawaii	X		
Idaho	X		
Illinois		X	
Indiana	X		
Iowa	X*		
Kansas	X		
Kentucky	X		
Louisiana		X	
Maine	X		
Maryland			X
Massachusetts	X		
Michigan	X		
Minnesota	X		
Mississippi	X		
Missouri		X	
Montana		X	
Nebraska			X
Nevada	X		
New Hampshire	X		
New Jersey	X		
New Mexico	X		
New York	X		
North Carolina	X		
North Dakota	X		
Ohio			X
Oklahoma	X		
Oregon	X		
Pennsylvania	X		
Rhode Island	X		
South Carolina			X
South Dakota			X
Tennessee			X
Texas	X		
Utah	X		
Vermont	X		
Virginia	X		
Washington	X		
West Virginia		X	
Wisconsin	X		
Wyoming	X		
District of Columbia	X*		
Puerto Rico	X		
	36	6	8

36 State Commissioners of Insurance, or 72 percent of all Commissioners (not including the District of Columbia and Puerto Rico who also responded affirmatively) polled by the Committee in a December 6, 1978 questionnaire, reported that companies who sell dread disease policies have employed fear tactics to promote their policies. A number of Commissioners who responded positively to this question reported they feel that fear tactics are used to promote dread disease policies as well as other forms of health insurance. These Commissioners are indicated by asterisks(\*). In addition, 6 Commissioners, or 12 percent of those responding, felt that companies who sell dread disease policies do not employ fear tactics to promote their policies, while 8 Commissioners, or 16 percent of all Commissioners had no comment.

DREAD DISEASE POLICIES

STATE COMMISSIONERS RESPONSE TO:

Do you agree that dread disease policies have very limited economic value?

<u>STATE</u>	<u>YES</u>	<u>NO</u>	<u>NO COMMENT</u>
Alabama		X	
Alaska			X
Arizona	X		
Arkansas	X		
California		X	
Colorado		X	
Connecticut	X		
Delaware	X		
Florida	X		
Georgia		X	
Hawaii			X
Idaho	X		
Illinois	X		
Indiana		X	
Iowa	X		
Kansas	X		
Kentucky		X	
Louisiana			X
Maine	X		
Maryland		X	
Massachusetts	X		
Michigan	X		
Minnesota		X	
Mississippi		X	
Missouri	X		
Montana		X	
Nebraska			X
Nevada			X
New Hampshire	X		
New Jersey	X		
New Mexico	X		
New York	X		
North Carolina	X		
North Dakota	X		
Ohio			X
Oklahoma		X	
Oregon			X
Pennsylvania	X		
Rhode Island		X	
South Carolina			X
South Dakota			X
Tennessee		X	
Texas			X
Utah	X		
Vermont	X		
Virginia	X		
Washington		X	
West Virginia	X		
Wisconsin	X		
Wyoming	X		
District of Columbia	X		
Puerto Rico		X	
	26	14	10

26 State Commissioners of Insurance, or 52 percent of all Commissioners (not including the District of Columbia or Puerto Rico) polled by the Committee in a December 6, 1978 questionnaire, agreed that dread disease policies have very limited economic value. 14 Commissioners, or 28 percent of those responding, reported they believe that such policies do have economic worth, while 10 Commissioners, or 20 percent of all Commissioners had no comment.

DREAD DISEASE POLICIES

## STATE COMMISSIONERS RESPONSE TO:

Do you agree that most people would be better off if they improved their comprehensive coverage as opposed to buying a single disease policy?

STATE	YES	NO	NO COMMENT
Alabama		X	
Alaska			X
Arizona		X	
Arkansas			X
California	X		
Colorado	X		
Connecticut	X		
Delaware			X
Florida	X		
Georgia	X		
Hawaii	X		
Idaho	X		
Illinois	X		
Indiana	X		
Iowa	X		
Kansas	X		
Kentucky			X
Louisiana	X		
Maine	X		
Maryland	X		
Massachusetts	X		
Michigan	X		
Minnesota		X	
Mississippi		X	
Missouri	X		
Montana		X	
Nebraska			X
Nevada	X		
New Hampshire	X		
New Jersey	X		
New Mexico	X		
New York	X		
North Carolina	X		
North Dakota	X		
Ohio			X
Oklahoma	X		
Oregon	X		
Pennsylvania	X		
Rhode Island			X
South Carolina			X
South Dakota			X
Tennessee	X		
Texas	X		
Utah			X
Vermont	X		
Virginia	X		
Washington	X		
West Virginia	X		
Wisconsin	X		
Wyoming	X		
District of Columbia	X		
Puerto Rico			X
	35	5	10

35 State Commissioners of Insurance, or 70 percent of all Commissioners (not including the District of Columbia who responded affirmatively) polled by the Committee in a December 6, 1978 questionnaire, agreed that most people would be better off if they improved their comprehensive coverage as opposed to buying a single disease policy. 5 Commissioners, or 10 percent of those responding, reported they did not believe that most people would be better off if they improved their comprehensive coverage as opposed to buying a single disease policy, while 10 Commissioners, or 20 percent had no comment.

## VI. RESPONSE FROM THE INDUSTRY: A POLL OF HEALTH INSURANCE COMPANIES

In order to learn the industry's view of dread disease insurance, a questionnaire was prepared and sent to the 50 largest companies in the health insurance field on December 6, 1978. The questionnaire again referred to the conclusions reached in the June 1978 edition of *Consumer Reports* and asked if insurance company executives agreed that such policies have limited economic value, if fear tactics were used to market the insurance, and whether consumers were better off expanding their existing coverage rather than buying a single disease policy. According to the Congressional Research Service of the Library of Congress, the 50 companies polled control more than half of the health insurance market.

Some 48 of the top 50 health insurers in the United States answered the poll. Most companies felt there was good reason for concern about the growing sales of cancer and related dread disease policies and the methods used in marketing the product. The results of the questionnaire are detailed below but must be qualified because results show few of the top 50 sell cancer insurance.

### RESULTS OF THE SURVEY

*Asked if they would agree that dread disease policies have very limited economic value, 26 of the top 50 insurance companies, or 52 percent of the total, answered in the affirmative. Fifteen companies, or 30 percent, answered in the negative. Seven companies, or 14 percent, had no comment and two more representing the remaining 4 percent did not answer the Committee's inquiry.*

*Asked if they would go so far as to charge that dread disease policies "were close to being a worthless product" only 8 companies, or 16 percent, responded in the affirmative, while 22 companies, or 44 percent of the total answered in the negative. Two companies made no response for 4 percent of the total and 18 companies for 36 percent had no comment to the question.*

With respect to both of these two questions, many companies who did not respond affirmatively said their answers would depend on the loss ratios of the dread disease policies. They said that while they knew of few such policies marketed with loss ratios in the 60 or 70 percent range, that such returns were possible. A dread disease policy which returns 70 percent or more of premiums to the insured might well have economic value and would be far from a worthless product, they argued.

As noted above, the General Accounting Office, in response to the Committee's inquiry, established that the loss ratio index, the percent of premiums returned to the insured in the form of claims, is a valid test of economic value. In GAO's survey of companies selling dread disease policies, only two companies were found to have an aggregate loss ratio as high as 60 percent.

The third question posed to insurance executives was: *Do you believe that companies selling these products employ fear tactics to promote their policies?* Only 7 companies, or 14 percent of the total answered in the affirmative and the same number answered in the negative. Fully 34 companies, or 68 percent of the total had no comment, and, of course, 2 companies or 4 percent did not reply to the survey.

The fourth question was: *Do you agree that most people would be better off if they improved their comprehensive coverage as opposed to buying a single disease policy?* There was overwhelming agreement on this question with 35 companies or 70 percent of the total answering in the affirmative. Only 5 companies disagreed representing 10 percent, 8 companies (16 percent) had no comment and 2 companies (4 percent) did not answer the questionnaire.

#### COMPARISON WITH RESPONSE OF STATE INSURANCE COMMISSIONERS

A comparison of the responses of the top 50 health insurers and the State insurance commissioners as detailed in Section V of this report indicates more similarities than differences.

Some 70 percent of the commissioners said people were better off expanding their existing policies rather than buying single disease policies as compared to 70 percent of the company executives who felt this way. Some 26 commissioners, or 52 percent of the total, were willing to go on record as saying dread disease policies have limited economic value as compared to 52 percent of the company executives. Ten commissioners or 20 percent said cancer insurance was a worthless product while only 8 companies for 16 percent would agree with the statement.

The one area where there were marked differences was on the question of whether insurance companies use fear tactics to promote their policies. Even though the vast majority of the nation's top 50 insurers do not sell dread disease insurance, their attitude was still protective. Only 7 companies, or 14 percent of the total, answered that companies use fear tactics to sell this kind of insurance. This contrasts with a significant 72 percent (36 commissioners) who were willing to go on record as saying companies commonly use fear tactics to promote cancer and other single disease policies.

Tables indicating the responses of each of the top 50 health insurance companies to the questions asked are carried at the end of this section.

#### SELECTIVE COMMENTS FROM INSURANCE COMPANIES ABOUT DREAD DISEASE INSURANCE

In order to provide a broader perspective, selective comments taken from the responses of many companies in the health insurance field are carried below. Most letters came in response to the Committee's questionnaire, a few others came in response to publicity generated by the Committee's November 28, 1978 hearings on the subject of abuses in the sale of health insurance to the elderly.

*Aetna Life and Casualty* of Hartford, Connecticut wrote that it does not sell dread disease insurance:

As you may know, the Connecticut General Assembly in 1975, at the request of the Insurance Department, enacted a

law prohibiting the sale of dread disease insurance policies in this state. We support this legislative and regulatory judgment that these policies are not a prudent means of acquiring adequate health care protection. Because we do not believe these policies provide sufficient economic value to our policyholders, we do not market them in any state.

*American Exchange Life* of Dallas, Texas sells cancer insurance and describes it as a "very worthwhile product":

In reviewing our claims they range in age from 6 to over 80. Most are above age 45. The smallest claim is for skin cancer of \$50.00 and so far our largest claim has been \$12,224.27. . . . Cancer insurance should be owned by everyone until we find a cure for this dreadful and expensive disease. You may be sure that the companies selling it will all be glad when a cure is found so that this policy will no longer be necessary. Until then we will do all we can to make everyone we contact aware of the importance of an early check-up and give them the facts from the American Cancer Society. I am sure you will do your part to support our sincere effort.

*American National Insurance Company* of Galveston, Texas said:

Although American National offers a wide range of individual health insurance coverages, at the present time we do not market dread disease policies. However, we do feel that such coverages are valid and have a place in the market. While a dread disease policy is certainly not a substitute for comprehensive health coverage, it can serve as a valuable supplement to existing hospitalization and major medical policies.

*American United Life Insurance Company* of Indianapolis, Indiana said it does not offer dread disease policies "because we feel that coverage for all causes is more important."

According to recent U.S. vital statistics reports, deaths due to cancer account for only 17.4 percent of all deaths. Advancements in medicine are allowing better control of the disease and improved recovery rates. Consequently, one problem with a dread disease policy is that as the risk is reduced, the premium remains the same. Thus the policy becomes valueless . . .

*Bankers Life* of Des Moines, Iowa said that dread disease policies "being selective in coverage, they tend to be relatively low in cost. They are also relatively low in value, although 'worthless' is somewhat of an overstatement."

*Bankers Life and Casualty* of Chicago, Illinois answered that if a cancer policy has a good premium benefit ratio, it will have good economic benefit. Bankers made the interesting point:

We do not market dread disease policies to senior citizens since Medicare and Medicare Supplements are comprehensive. There is no need for dread disease coverage where comprehensive insurance does exist.

The significance of this comment is that given the nature of the Medicare program, and the universal nature of Medicare supplemental

insurance it is hard to see how limited disease policies fit into the over-65 market. The irony as documented in the Committee's study and that of the Massachusetts Department of Insurance, summarized in Section V of this report, is that the bulk of these policies are being sold to older Americans.

*Chesapeake Life Insurance Company* of Baltimore, Maryland wrote that cancer insurance has limited economic value and is close to being a worthless product, and added these interesting comments:

Dread disease policies have given me considerable pause for thought over the past many years. I first ran into them in the early 30's when I was an agent and found people buying a polio policy for a small sum of money. I talked myself blue in the face with my various clients that they were throwing their money away, but to no avail; they still bought them. Actually, I think the dread disease policies fall into the same class as trip accident policies for airplanes, or having a policy with a premium of 25 cents that will indemnify me with a million dollars if struck by lightning within one mile of my residence during the year. The premium is negligible, the benefits are high, but the risk is far more negligible than the premium.

But we strike at the heart of one of the problems of consumerism that I do not know the answer to: Do we, as a company, only provide what the public truly needs, or do we try to provide them with what they want? And they truly want some peculiar things. Should we depend upon our educational systems for educating the people not to want these ridiculous items, or should we follow the marketing studies to provide what they want whether they need it or not?

For about ten years now I have been fighting against bringing out a cancer policy, but the demand—public and our agency force—could bring us to doing so. We lost one large agency a few years ago because we refused to provide a cancer product that some other company was willing to put in their portfolio.

*Commonwealth Life Insurance Company* of Louisville, Kentucky wrote that they offer only cancer insurance which they believe is of benefit to life insurance policyholders who are their prime purchasers. They provided this interesting comment about fear tactics:

We must all recognize that the definition of "fear tactics" will vary from individual to individual, and that in discussion of a subject as frightening as cancer the line between "conscientious advice" and "fear tactics" may be very thin (and becomes a matter of opinion).

*The Commonwealth National Life Insurance Company* of Cleveland, Mississippi wrote about its involvement with cancer insurance:

In 1971, an agent for another insurance company called on my father to sell him a cancer insurance policy for his employees. The program interested him and he sent me to Jackson to look at their financial statement and to find out what I could about this product that they were offering.

My investigation of this market revealed that these people were making an exorbitant profit on this very marketable

product. We felt that it was an area that could be vastly improved and was wide open to other companies that wanted to enter the market on a competitive basis. Consequently, we have sold cancer policies since 1971 which offer higher benefits at lower premiums than virtually any other company in the market. We have also been responsible for several innovations which we feel have cleaned up the market, presented a fairer picture of the coverage offered, and provided greater benefits for our clients. In the past, brochures for these policies usually showed some very high figure, such as \$50,000.00 as the maximum amount that the insured could receive, even though this did not reflect the normal payout that they could expect. Through our efforts with the Mississippi Insurance Department, this practice has been stopped. We are also responsible for instituting a standard 30 day waiting period in this type of policy, whereas in the past the waiting periods were up to 120 days. I could go on and on with other improvements that we have made but suffice that we feel our entry into this market has improved it quite a bit.

We also have a unique approach in the industry to our treatment of older people. Whereas many companies charge much higher premiums for the older ages, or increase the premium when a person retires, we charge one uniform rate, no matter what the age or employment. I have seen many policies that charge three or four times higher premium rates at the older ages, and feel that this practice is wrong. In short I guess I am saying that our company has been responsive to the problems that have been pointed out by the Select Committee in the past and will continue to be so in the future.

*Connecticut General* of Hartford, Connecticut notes that it does not sell dread disease insurance and added this comment :

Insurance coverages such as dread disease policies deal with events which are infrequent in number of occurrences, but have a high economic impact when they do happen. The policy has little value (other than possibly peace of mind) for the majority who do not experience the disease, but can have substantial value to the few where benefits are payable.

*Connecticut Mutual* also of Hartford said :

While most knowledgeable insurance people would not purchase for themselves a dread disease policy except in unusual circumstances, there is a certain danger with respect to sweeping generalizations as to these policies' "economic value" or "worthlessness." The real problem is, of course, not that the products are worthless but that relatively little of the premium dollar finds its way to the benefit side of the ledger.

*Equitable Life Insurance Company* of Des Moines, Iowa had this comment :

We do not include dread disease policies in our portfolio of products. We do not feel that they have economic value of any note and would agree that some type of comprehensive cov-

erage would certainly be much preferable to a single dread disease type of policy.

The *General American Life Insurance Company* of St. Louis, Missouri said:

Our company does not sell dread disease policies. They have limited economic value. They are not worthless but because the benefits paid to the policyholders as a class are so limited, a disproportionate part of the premium is consumed by selling and administrative costs. I have no direct personal experience but my impression of the advertising I have seen is that at least some companies selling these products employ fear tactics to promote their policies.

*Guardian Life Insurance Company* of New York, New York agreed that single disease policies have very limited economic benefit saying, "they represent a very unwise purchase for most people." The company added it does not sell such policies:

[I]t is our impression that unduly high pressure is often used by some of the salesmen who peddle these products, and it is our impression that the sales talks are often intended to create the impression that the dread disease policy is supposed to cover is the only one that is likely to seriously threaten the prospective buyer's financial stability. Such tactics, to the extent they are used, are misleading and deceptive, and we deplore them.

The *Imperial Life Assurance Company* of Canada wrote:

I personally am opposed to the dread disease policies in general, not because they may have little economic value or may be worthless but rather because they are speculative and relate more to a gambling risk than an insurance risk.

*Liberty National Life Insurance Company* of Birmingham, Alabama said that it sells cancer insurance and that it takes pains to explain the limited nature of the policies before customers buy them. The company added that in the last 63 claims under their cancer policies where death was finalized, their average claim was \$3,380.52 ranging from "less than \$500 to over \$11,500."

We currently have one active claim . . . where we have paid in excess of \$70,000 under a cancer policy. Thus, our experience reflects the very real economic value of these policies.

*Metropolitan Life* of New York, New York answered as follows:

We only sell medical expense policies which we expect will in the aggregate return to the group of policyholders amounts of claim dollars which exceed certain percentages of the aggregate premiums paid. In addition to the claim to premium tests, we believe that medical expense policies should be reasonably comprehensive in their scope of coverage. We do not and have not sold dread disease policies because they generally fail to meet these two tests.

The *Monumental Life Insurance Company* of Baltimore, Maryland had this comment :

Cancer insurance is relatively new in our industry and historically the public, the regulators and our industry itself is slow to accept new products. We believe, however, that there is a genuine need for this coverage and that the cancer policy fulfills that need.

It is my belief that the only possible criticism which can be made is in the marketing approach. We readily agree that cancer insurance should not be sold through fear tactics. We further agree that it should be as "supplemental" coverage, not as a replacement for other general or comprehensive plans of life or health insurance. It is properly explained and marketed,—and there are stringent state insurance laws to police agent or advertising misrepresentation ;—then we believe this to be a valuable coverage filling a real insurance need.

*Mutual of Omaha*, which sells cancer insurance is convinced of the value of these policies. With respect to the use of fear tactics they said :

There may be some companies that are emphasizing the fearsome result of not having sufficient coverage against cancer, for example. However, we must recognize that this fear is not completely unfounded. Cancer is a dread disease. It does take a dreadful toll on the financial as well as the physical well-being of the affected individual as well as the family. That this fear is a motivating force there is no doubt. Isn't that why Senator Humphrey, who was covered by cancer insurance, said in a Washington interview with *Women's News Service* in May, 1977, "There is a place for supplemental insurance in America. I think people ought to look for it . . ."

*Nationwide Insurance* of Columbus, Ohio said they provide cancer coverage but only as a supplement to other policy benefits: "We do not actively merchandise these policies because we feel they are only valuable as a supplement to existing coverage."

*Pacific Mutual* of Newport Beach, California answered that dread disease policies are close to being a worthless product, adding :

Dread disease policies, by their nature, have a low frequency of claims. This may be interpreted to mean that they have little economic value on the average, even though a particular claim may be large. As a result, the premium is small as compared with more comprehensive coverage. It is a small price for a large benefit which occurs infrequently. The allure is in the small premium which is easy for people to pay.

There should be no argument that most people would be better off if they purchased or improved their comprehensive coverage as opposed to buying a single dread disease policy.

*Provident Mutual* of Philadelphia, Pennsylvania had this to say :

We would agree that dread disease policies probably have little economic value and are of questionable worth to the very large majority of persons insured under them . . .

It is our feeling that one real shortcoming of the dread disease policy is that it tends to provide a false sense of security to many insureds. We would suspect that often too much reliance is placed on such policies—sometimes because of a lack of full understanding as to the coverage actually provided. We definitely feel that most people would be better off diverting dread disease premium dollars toward improving their comprehensive medical expense programs.

The *Prudential Insurance Company* of Newark, New Jersey said that it does not market dread disease insurance and offered these two “concerns” with respect to such coverage:

We believe it extremely important that those who purchase such policies understand what they are purchasing and the relatively limited nature of the benefit provided. They should clearly understand that such policies do not provide them protection against a wide range of the types of medical expenses to which they may subsequently become exposed.

We believe such policies should not be offered unless it is possible to do so on a basis under which the benefits payable are reasonable in relationship to the premiums.

*Public Life Savings Insurance Company* of Charleston, South Carolina, provided this insight:

When the dread disease policies were first issued by insurance companies, they were outstanding policies. I even bought one myself, and sold some, although I would not even sell a hospitalization policy. I mainly sold life insurance. The original policy was a dread disease policy and would pay up to \$25,000 for any of the diseases listed. Then, the crooked lawyers, crooked hospitals and doctors took these policies and everytime someone got as much as skin cancer, they ran up \$25,000 worth of claims. This almost bankrupt some companies I am familiar with. As it is now, I do not feel these policies are worth too much and we do not sell them.

*State Farm Life Insurance Company* of Bloomington, Illinois agreed that cancer policies have limited economic benefit adding: “The product ends up being extremely overpriced for the coverage. Some companies engage in fear tactics but I would not say this is a blanket indictment for all companies.”

The *State Mutual Life Assurance Company* of Worcester, Massachusetts said:

We are answering all your four questions in the affirmative. We concur completely in the *Consumer Reports* article that dread disease policies have little or no economic value and that most people would obtain far better value for their money from the type of comprehensive medical care coverages offered by State Mutual and, in fact, by the great majority of responsible insurers.

*Teachers Insurance and Annuity Association of America* also had a negative view of dread disease insurance:

Single-risk insurance policies specifying an insured risk limited to one widely-feared disease are likely to give a false

sense of security to persons who are normally unaware of the small degree of risk involved for particularly named disease. Insurance premium dollars are better spent for more comprehensive and broad risk medical insurance protection.

The *Travelers Insurance Companies* of Hartford, Connecticut said that "properly priced" dread disease could provide reasonable economic benefit:

By its nature dread disease is a supplemental type coverage which may provide valuable reassurance to those who purchase it. A person may derive substantial psychological benefit from it in much the same way he may from the additional protection provided by travel or accidental death coverage.

*Washington National* of Evanston, Illinois, a seller of cancer insurance, defended the virtues of dread disease policies:

The demand for cancer coverage created by these campaigns has been phenomenal. Recently a representative from the Illinois Insurance Department advised us that more requests for information with respect to the purchase of cancer policies were received by the department than requests for any other type of coverage. The person purchasing such coverage receives a certain peace of mind which has an incalculable value.

The same can be said of cancer policies, although they are of far more economic value than flight insurance. One who is unable or unwilling to pay the cost of a comprehensive health insurance program, which cost may exceed \$2,000 per year, may be anxious to obtain coverage for what is believed to be an equally imminent danger—that is, cancer—at a cost of no more than \$10 to \$50 annually. Less emphasis on this disease on the part of numerous federal agencies would reduce demand for such policies, but we are not certain that less emphasis would be in the public interest.

#### SUMMARY

A few generalizations can be drawn as a result of this questionnaire to the nation's 50 largest health insurers. In the first place, few of them actively sell cancer or related dread disease policies. Naturally, those companies that have made the decision to do so defended their actions. However, even the companies who were in the business of selling such policies were in general agreement that individuals are better off expanding their existing coverage rather than to buy an isolated dread disease policy. Therefore it is clear that there would be a good deal of support within the top 50 insurers for a ban on the sale of cancer or related dread disease insurance unless it were sold as an adjunct to an existing comprehensive health insurance policy.

It was clear from the responses that many companies feel that consumers may be lulled into a false sense of security with the purchase of cancer insurance. The low price of such policies, they charge, promotes a "something for nothing mentality" in which most consumers are bound to come out as losers. Several companies noted that while they

have resisted the cancer insurance business, the demand from consumers and the financial success of their competitors may force them to enter the field.

There seemed to be a general consensus that some companies use fear tactics to promote their cancer policies although company executives were reluctant to lay that charge to the majority of companies that specialize in dread disease sales. However, there were many oblique references to unfair "marketing tactics" which usually translated into a charge that some companies capitalized on the "something for nothing mentality" of some consumers. It was clear that some companies are cashing in on the low price of cancer or dread disease policies promising large benefits to the insured. These large benefits, of course, seldom materialize for most people. While most companies were repulsed by these tactics, a few endorsed them in the name of *laissez-faire* and "let the buyer beware."

On the subject of the economic value of dread disease policies, the weight of opinion was that they have comparatively little value for most people. If the question asked had been stated as follows: "Do you agree that dread disease policies that generally have loss ratios well below 50 percent have limited economic benefit?" almost all insurance company executives would have answered in the affirmative. As it was, 52 percent or 26 of the top 50 were willing to go on record as saying the policies had limited economic value. Few were willing to go so far as to say the policies were worthless. Several executives mentioned that the policies may bring peace of mind or perhaps more accurately the illusion of peace of mind to the buyer and that this feeling of well-being—even if misguided—is worth something.

A final generalization is that insurance company executives seemed to agree that there would be little value for senior citizens who already have comprehensive medical protection in the form of Medicare, Medicaid, and broad gauge supplementary policies, to purchase dread disease insurance.

DREAD DISEASE POLICIES

TABLE 1

Question: Do you agree that dread disease policies have very little economic value?

NAME OF COMPANY	YES	NO	NO COMMENT	NO ANSWER
Aetna Life Insurance Company	X			
American National Insurance Co.		X		
American United Life Insurance Co.		X		
Bankers Life	X			
Bankers Life & Casualty Co.		X		
Commonwealth Life Insurance Co.		X		
Connecticut General Life Ins. Co.	X			
Connecticut Mutual Life Insurance Co.	X			
Continental Assurance Co. (CNA)		X		
Equitable Life Assur. Soc. of the U.S.			X	
Equitable Life Insurance Co. of Iowa	X			
Franklin Life Insurance Co.	X			
General American Life Insurance Co.	X			
Guardian Life Ins. Co. of America	X			
Home Life Ins. Co. of New York	X			
Jefferson Standard Life Ins. Co.				X
John Hancock Mutual Life Ins. Co.			X	
Kansas City Life Insurance Co.				X
Liberty National Life Insurance Co.		X		
Life Insurance Co. of Virginia	X			
Lincoln National Life Insurance Co.	X			
Massachusetts Mutual Life Ins. Co.			X	
Metropolitan Life Insurance Co.	X			
Minnesota Mutual Life Insurance Co.	X			
Mutual Benefit Life Insurance Co.		X		
Mutual of New York (MONEY)	X			
Mutual of Omaha		X		
National Life Insurance Company	X			
National Life & Accident Ins. Co.		X		
Nationwide Life Insurance Co.	X			
New England Mutual Life Ins. Co.			X	
New York Life Insurance Co.			X	
Northwestern Mutual Life Ins. Co.			X	
Northwestern National Life Ins. Co.			X	
Occidental Life Ins. of California	X			
Pacific Mutual Life Insurance Co.	X			
Penn Mutual Life Insurance Co.	X			
Phoenix Mutual Life Insurance Co.	X			
Pilot Life Insurance Co.		X		
Provident Life & Accident Ins. Co.		X		
Provident Mutual Life Ins. Co.	X			
Prudential Ins. Co. of America	X			
Southwestern Life Insurance Co.	X			
State Farm Life Insurance Co.	X			
State Mutual Life Assur. Co. of Amer.	X			
Teachers Ins. & Annuity Assn. of Amer.	X			
Travelers Corporation		X		
Union Central Assurance Corporation		X		
Washington National Insurance Co.		X		
Western-Southern Life Ins. Co.		X		
TOTAL	26	15	7	2

DREAD DISEASE POLICIES

TABLE 2

Question: Do you agree that they (dread disease policies) are close to being a worthless product?

NAME OF COMPANY	YES	NO	NO COMMENT	NO ANSWER
Aetna Life Insurance Company			X	
American National Insurance Co.		X		
American United Life Insurance Co.			X	
Bankers Life			X	
Bankers Life & Casualty Co.		X		
Commonwealth Life Insurance Co.		X		
Connecticut General Life Ins. Co.		X		
Connecticut Mutual Life Insurance Co.		X		
Continental Assurance Co. (CNA)		X		
Equitable Life Assur. Soc. of the U.S.			X	
Equitable Life Insurance Co. of Iowa			X	
Franklin Life Insurance Co.		X		
General American Life Insurance Co.		X		
Guardian Life Ins. Co. of America		X		
Home Life Ins. Co. of New York		X		
Jefferson Standard Life Ins. Co.				X
John Hancock Mutual Life Ins. Co.			X	
Kansas City Life Insurance Co.				X
Liberty National Life Insurance Co.		X		
Life Insurance Co. of Virginia	X			
Lincoln National Life Insurance Co.		X		
Massachusetts Mutual Life Ins. Co.			X	
Metropolitan Life Insurance Co.			X	
Minnesota Mutual Life Insurance Co.	X			
Mutual Benefit Life Insurance Co.		X		
Mutual of New York (MONY)			X	
Mutual of Omaha		X		
National Life Insurance Company			X	
National Life & Accident Ins. Co.		X		
Nationwide Life Insurance Co.			X	
New England Mutual Life Ins. Co.			X	
New York Life Insurance Co.			X	
Northwestern Mutual Life Ins. Co.			X	
Northwestern National Life Ins. Co.			X	
Occidental Life Ins. of California			X	
Pacific Mutual Life Insurance Co.	X			
Penn Mutual Life Insurance Co.	X			
Phoenix Mutual Life Insurance Co.	X			
Pilot Life Insurance Co.		X		
Provident Life & Accident Ins. Co.		X		
Provident Mutual Life Ins. Co.		X		
Prudential Ins. Co. of America			X	
Southwestern Life Insurance Co.	X			
State Farm Life Insurance Co.			X	
State Mutual Life Assur. Co. of Amer.	X			
Teachers Ins. & Annuity Assn. of Amer.	X			
Travelers Corporation		X		
Union Central Assurance Corporation		X		
Washington National Insurance Co.		X		
Western-Southern Life Ins. Co.		X		

TOTAL

8

22

18

2

DREAD DISEASE POLICIES

TABLE 3

Question: Do you believe that companies selling these products (dread disease insurance) employ fear tactics to promote their policies?

NAME OF COMPANY	YES	NO	NO COMMENT	NO ANSWER
Aetna Life Insurance Company			X	
American National Insurance Co.		X		
American United Life Insurance Co.			X	
Bankers Life			X	
Bankers Life & Casualty Co.		X		
Commonwealth Life Insurance Co.			X	
Connecticut General Life Ins. Co.			X	
Connecticut Mutual Life Insurance Co.			X	
Continental Assurance Co. (CNA)			X	
Equitable Life Assur. Soc. of the U.S.			X	
Equitable Life Insurance Co. of Iowa			X	
Franklin Life Insurance Co.	X			
General American Life Insurance Co.			X	
Guardian Life Ins. Co. of America	X			
Home Life Ins. Co. of New York			X	
Jefferson Standard Life Ins. Co.				X
John Hancock Mutual Life Ins. Co.			X	
Kansas City Life Insurance Co.				X
Liberty National Life Insurance Co.		X		
Life Insurance Co. of Virginia			X	
Lincoln National Life Insurance Co.	X			
Massachusetts Mutual Life Ins. Co.			X	
Metropolitan Life Insurance Co.			X	
Minnesota Mutual Life Insurance Co.	X			
Mutual Benefit Life Insurance Co.			X	
Mutual of New York (MONY)			X	
Mutual of Omaha		X		
National Life Insurance Company			X	
National Life & Accident Ins. Co.			X	
Nationwide Life Insurance Co.			X	
New England Mutual Life Ins. Co.			X	
New York Life Insurance Co.			X	
Northwestern Mutual Life Ins. Co.			X	
Northwestern National Life Ins. Co.			X	
Occidental Life Ins. of California			X	
Pacific Mutual Life Insurance Co.	X			
Penn Mutual Life Insurance Co.			X	
Phoenix Mutual Life Insurance Co.			X	
Pilot Life Insurance Co.		X		
Provident Life & Accident Ins. Co.			X	
Provident Mutual Life Ins. Co.			X	
Prudential Ins. Co. of America			X	
Southwestern Life Insurance Co.			X	
State Farm Life Insurance Co.			X	
State Mutual Life Assur. Co. of Amer.	X			
Teachers Ins. & Annuity Assn. of Amer.			X	
Travelers Corporation		X		
Union Central Assurance Corporation		X		
Washington National Insurance Co.	X			
Western-Southern Life Ins. Co.			X	

TOTAL

7

7

34

2

DREAD DISEASE POLICIES

TABLE 4

Question: Do you agree that most people would be better off if they improved their comprehensive coverage as opposed to buying a single dread disease policy?

NAME OF COMPANY	YES	NO	NO COMMENT	NO ANSWER
Aetna Life Insurance Company	X			
American National Insurance Co.	X			
American United Life Insurance Co.	X			
Bankers Life	X			
Bankers Life & Casualty Co.	X			
Commonwealth Life Insurance Co.		X		
Connecticut General Life Ins. Co.	X			
Connecticut Mutual Life Insurance Co.	X			
Continental Assurance Co. (CNA)			X	
Equitable Life Assur. Soc. of the U.S.			X	
Equitable Life Insurance Co. of Iowa	X			
Franklin Life Insurance Co.	X			
General American Life Insurance Co.	X			
Guardian Life Ins. Co. of America	X			
Home Life Ins. Co. of New York	X			
Jefferson Standard Life Ins. Co.				X
John Hancock Mutual Life Ins. Co.			X	
Kansas City Life Insurance Co.				X
Liberty National Life Insurance Co.		X		
Life Insurance Co. of Virginia	X			
Lincoln National Life Insurance Co.	X			
Massachusetts Mutual Life Ins. Co.	X			
Metropolitan Life Insurance Co.	X			
Minnesota Mutual Life Insurance Co.	X			
Mutual Benefit Life Insurance Co.	X			
Mutual of New York (MONY)	X			
Mutual of Omaha	X			
National Life Insurance Company	X			
National Life & Accident Ins. Co.	X			
Nationwide Life Insurance Co.	X			
New England Mutual Life Ins. Co.			X	
New York Life Insurance Co.			X	
Northwestern Mutual Life Ins. Co.			X	
Northwestern National Life Ins. Co.			X	
Occidental Life Ins. of California	X			
Pacific Mutual Life Insurance Co.	X			
Penn Mutual Life Insurance Co.	X			
Phoenix Mutual Life Insurance Co.	X			
Pilot Life Insurance Co.		X		
Provident Life & Accident Ins. Co.	X			
Provident Mutual Life Ins. Co.	X			
Prudential Ins. Co. of America			X	
Southwestern Life Insurance Co.	X			
State Farm Life Insurance Co.	X			
State Mutual Life Assur. Co. of Amer.	X			
Teachers Ins. & Annuity Assn. of Amer.	X			
Travelers Corporation	X			
Union Central Assurance Corporation		X		
Washington National Insurance Co.	X			
Western-Southern Life Ins. Co.		X		
TOTAL	35	5	8	2

## VII. THE SPECIAL PROBLEM OF MAIL ORDER INSURANCE

An increasing number of groups, associations, unions, financial institutions, and even government agencies have been sharing their membership lists with insurance companies, giving them the right to solicit their membership for cancer insurance. Examples of these groups include the National Rifle Association, the Sigma Phi Epsilon Fraternity, the American Federation of Teachers and various credit card companies.<sup>1</sup> For its part, the cooperating organization is paid a percentage of gross sales. A certain amount of the insurance premiums, perhaps 5–10 percent, paid by subscribing members is given to the organization. Insurance companies, obviously, have been able to increase sales dramatically given what appears to be an endorsement of their product by the organization involved. The question is: Does the consumer benefit?

In many instances, the answer is negative. As indicated throughout this report, there is very limited economic value in the purchase of cancer or other dread disease policies. Since mail order firms do not employ salesmen—the largest cost facing other insurers—their costs should be lower and the amount of premiums returned in the form of claims should be higher than other insurance companies. Unfortunately, this isn't so. The average loss ratio for companies in the health insurance industry is 80 percent. Most mail order firms average less than 50 percent which is ample evidence that they are retaining high profits. The series of policies with the lowest loss ratios overall are mail order cancer and dread disease lines—loss ratios in the 10 to 20 percent range are not uncommon.

The opportunity for abuse is multiplied many times over because the State insurance commissioners of the respective States do not have the authority to step in and regulate cancer or any other policies sold through interstate mail. The policies offered need not be filed with and approved by them, hence, companies can, in their advertising, make grandiose claims about their product, while in their policies, use exclusions printed in small type so severely limiting benefits that the policy's value approaches zero. Should a consumer complain to them, State insurance commissioners are powerless to open an investigation and to obtain redress against a company whose only presence in their State is a solicitation passed through the mails.

The problem reaches the ridiculous extreme in States such as New York which have banned cancer insurance outright and/or by virtue of minimum benefit laws which require insurance companies to return at least 60 percent of premiums to their insured, a standard most cancer policies do not reach. Sadly, even in the face of these laws, New York and other States are powerless to stop the flow of mail order cancer policies into their States. In short, there is an obvious gap in

---

<sup>1</sup> For additional details see, "Guilt by Association," *Washington Monthly*, Feb. 1980, p. 10.

regulations which permits mail order sales of all kinds of questionable policies. Cancer insurance is now the new hot item for these direct response companies who have long been criticized for their marketing practices. A discussion of the general topic of mail order abuses is necessary in order to provide the full flavor of the onerous mail order cancer sales.

#### BACKGROUND

The special problems of mail order health insurance have been recognized since 1972 when the Senate Anti-Trust and Monopoly Subcommittee held its landmark hearings. In December 1974, the Senate Committee on Aging issued a report on "Private Health Insurance Supplementary to Medicare," which was sharply critical of mail order insurance policies which it said did not deliver what was expected of them. That report says that "the pattern of mail order deception is well known by now to the State Departments of Insurance throughout the nation." In June of 1976, *Consumer Reports* issued their findings on this subject:

Be particularly wary of mail order indemnity policies which are widely advertised. While some of the exaggeration has disappeared from mail order advertising since we last looked, the conclusions of that report still stand: Mail order coverage usually doesn't fit the needs of older people and the companies tend to promise more than they can deliver.

In its July 1978 report, the Federal Trade Commission called mail order group insurance a gap in State regulation. It said:

A substantial number of Medicare supplement and indemnity plans are sold to the elderly by mail. It is common for a direct response or mail order insurance company to be licensed in only one State and send its advertisements and solicitations to residents of other States. When an applicant responds, the company issues a policy in the State where it is licensed and sends it to the insured.

It now appears that State insurance departments are experiencing some difficulties in regulating the sale of group policies to supplement Medicare by an unlicensed out-of-State mail order insurer. Some Medicare supplement regulations govern only individual policies. Some, by their terms, apply only to policies issued in the State, and thus exempt many individual as well as group policies sold by mail. None of the States' standardization measures applies to unlicensed group order insurers. Policies can be a source of confusion for the elderly if they are not subject to their State's regulation. Federal involvement could ensure that all policies sold to supplement Medicare are subject to regulation.

Since there have been serious problems in the past, there is good reason for caution in the future.

#### WHICH COMPANIES SELL BY MAIL?

The following companies are the largest mail order insurers in the United States. They are listed alphabetically with the amount of pre-

miums they receive and claims paid in 1977 and the resulting loss ratio indicated for each. The source is the National Underwriter Co., June 1978 Argus Guide.

Company	Premiums received	Paid	Loss ratio
Beneficial Standard, Los Angeles, Calif. ....	\$33,277,000	\$19,262,000	57
Colonial Penn Franklin, Philadelphia, Pa. ....	52,558,000	32,745,000	61
Colonial Penn Life, Philadelphia, Pa. ....	230,558,000	145,745,000	63
Commercial Travelers Mutual, Utica, N.Y. ....	7,435,000	4,975,000	66
J. C. Panney, Buena Park, Calif. ....	19,166,000	7,266,000	37
Montgomery Ward, Chicago, Ill. ....	28,317,000	12,826,000	45
National Home Life Assurance, Jefferson City, Mo. ....	119,133,000	61,843,000	52
National Home Assurance, New York, N.Y. ....	1,507,000	771,000	51
Physician's Mutual, Omaha, Nebr. ....	91,326,000	56,095,000	61
Union Fidelity Life, Trevese, Pa. ....	40,265,000	18,288,000	45

All together, mail order insurance may constitute 4 percent of health insurance sold but fueled by escalating cancer sales, it is the fastest growing and least regulated segment of the industry.

#### PROBLEMS WITH MAIL ORDER INSURANCE

Critics charge that some mail order firms employ fear tactics to induce sales (particularly of cancer insurance) and that they (a) misrepresent policy coverages; (b) describe limitations on coverage as a bonanza to the policyholder; (c) offer policies that have limited economic benefit; (d) make liberal use of restrictive preexisting condition or other clauses to limit the company's liability to pay claims, and (e) exaggerate benefits payable by representing themselves as broad comprehensive insurance plans when in fact they provide limited indemnity (cash) benefits rather than service benefits.

#### A GAP IN REGULATIONS

Several State insurance commissioners reported to the Committee that they did not have authority to regulate mail order insurance. On the first level, many States lack the power to regulate any company that is not licensed to do business in the State. On the second level, less than half of the States have laws or regulations which will allow them to regulate advertisements and solicitations made through the mails. Finally, the third and most important level, none of the States has authority to regulate the sale of out-of-State group (as opposed to individual) insurance.

With respect to group insurance, a master policy is issued under the regulations of one State and policy certificates can then be sold through the mails to all members of the group (i.e. senior citizens, veterans) in each of the other 49 States. There is little or nothing a State insurance commissioner can do to stop the flow of solicitations or policy certificates into his State.

The State of California has forthright disclosure and minimum benefit requirements for all Medicare supplementary health insurance policies but as the recent FTC report points out, these rules do not apply to out-of-State group health insurance policies that are mailed into California. The FTC notes:

The California Department of Insurance does not believe that it could make those regulations applicable to group mail order or other group insurers where the master policy is issued in another jurisdiction. It views this legal constraint as a serious problem because of the inadequacy of some of the products sold by mail to California residents.

The essence of the gap in regulation is that the only presence insurance companies often have in a State is the solicitation for insurance which passes through the mails. The master group policy is filed in another State. The company is located in another State. The company generally has no assets in the State and it employs no agents who could be held accountable. If a citizen has a problem and contacts his local insurance commissioner, there is little the State official can do to bring about a redress of the grievance.

#### PHONY TRUSTS

The problem is exacerbated by the creation of phony trusts. The trust is a wholly-owned captive of the insurance company which sets it up with the single purpose of aiding in the sale of insurance, specifically to take delivery of mail order policies on behalf of the insured. The purpose, once again, is evasion of State laws. It works like this: An individual in Florida receives a solicitation for insurance from a Pennsylvania firm. He sends his check to the trust in Washington, D.C., which is a wholly owned subsidiary of the insurance company. The company in Pennsylvania sends the policy certificate to the trust in Washington, D.C. The trust will then pass on the policy to the individual in Florida. In the example, the delivery of the policy has been to the trust in Washington, D.C., and not directly to the individual in Florida. Consequently, there is no legal presence of the company in the State of Florida, and the Florida Commissioner has no threads to use in regulating the company or its policies.

Because they do not have to file their policies and gain approval of them, and because they are not answerable to State insurance commissioners, firms that specialize in mail order group sales enjoy a competitive advantage over firms which employ agents. This advantage should be turned into higher loss ratios and a better deal for consumers, but unfortunately, it usually becomes higher profits for the company. It goes without saying that because they are not filed with and approved by State insurance departments, mail order policies and/or certificates are often misleading, exaggerated, ambiguous and sometimes flatly unconscionable in their use of limitations and exclusions.

Testifying before the Committee on November 28, 1978, Commissioner Elizabeth Dole of the Federal Trade Commission offered this comment about mail order sales:

Many supplement and indemnity plans are sold by mail, and some States could not enforce medicare supplement regulations against mail order insurers not licensed in their States.

Ron Wyden, Esq., representing the Gray Panthers, added:

It is almost impossible to enforce our medicare supplement regulations against mail order insurers not licensed in Oregon. Many supplements, as we have heard, are sold by mail.

Perhaps even more significant in terms of this report was the testimony of New York Superintendent of Insurance Al Lewis. Superintendent Lewis offered the Committee an example of a mail order cancer policy which had been mailed into his State. He pointed out that the State of New York bans the sale of cancer insurance and yet the policies continue to flood his State. He added that the policy was an out-of-State group policy issued by a company through a trust in Washington, D.C. He said with frustration :

So we stop it in New York but unfortunately we cannot stop it from coming in the mail. They set up a fake trust. The trust doesn't exist. This is a legitimate organization but they set up a trust for the sole purposes of selling by mail a policy that is delivered, the certificate is delivered to the trust, and the person can buy it in my State. You could, I believe, make it very simple without involving yourself in the particular State's operation. If it is not a proper policy that could be sold in the State, it should not be sold through the U.S. Mail. That would be legislation that I would welcome and would still leave to the State the responsibility to control the type of traffic or commerce in insurance policies within the State.

Florida Insurance Commissioner Bill Gunter commented :

I share the views of Commissioner Lewis, Mr. Chairman. It would seem to me that the proper avenue for controlling a situation like this might well be through the U.S. mails over which obviously you have jurisdiction. The problem that we face in Florida, and it is similar to that in the State of New York, as expressed during the hearing, is that we will have a company that is not licensed to do business in Florida doing business through the U.S. mails, so that when consumer complaints occur we have no jurisdiction to reach out with our regulatory arm and do anything about it. So there is no way for us as State regulators to deal with the problem as described here in this hearing today, and I think we need your help in that regard.

Nevada Insurance Commissioner James Wadhams also informed the Committee that mail order insurance was a special problem and that he was having difficulty regulating out-of-State group insurance :

Nevada is very concerned about the group insurance sold to our elderly merely by making them part of a group trust. . . Nevada at the present time is looking closely at the National Senior Citizens Group Insurance Trust—group coverage underwritten by Union Fidelity Life. Attached you will find the initial request for information. Union Fidelity has not responded to my request to date.

The responses from several State insurance commissioners mentioned Union Fidelity Life Insurance Company and their use of the trust device. The Committee felt this deserved a closer look.

Since 1971 when its reported loss ratio was 33 percent according to *Consumer Reports*, Union Fidelity Life Insurance Company has been criticized as much as any company in the health insurance field. In its November 1978 staff report, the Committee found that its incidence of complaints was worse than most companies. Assuming the rough stand-

ard of .40 complaints per each \$100,000 of premiums is reasonable, Union Fidelity was over the mark in 1977 in each of five sample States:

Arizona -----	1. 03/\$100, 000
Missouri -----	3. 13/\$100, 000
South Carolina -----	5. 35/\$100, 000
Tennessee -----	3. 84/\$100, 000
Wisconsin -----	1. 57/\$100, 000

The company has been fined or disciplined by at least a dozen jurisdictions including California, the District of Columbia, Florida, Hawaii, Kansas, Massachusetts, New Hampshire, New Jersey, Puerto Rico, Vermont and West Virginia. A summary of the State of Massachusetts' market conduct examination of Union Fidelity cancer policies is carried in Section IV of this report.

Union Fidelity has established what it calls the National Senior Citizens Group Insurance Trust. It tells senior citizens that "you have been selected to take advantage of benefits offered by the trust. And best of all, you pay nothing to belong, not now not ever." The company's brochure goes on to explain what the trust does for seniors: (1) "helps answer those difficult questions about the right kind of insurance protection you should have at this time in your life", and (2) "most important of all, we offer you group insurance protection at low rates."

In short, the trust is a "come on" and the brochure is nothing more than a solicitation for insurance. The use of the trust allows the company to sell out-of-State group insurance. The customer is promised still more—a "durably finished in plastic handy wallet sized card (which) tells you at a glance the expenses you are required to pay if you are hospitalized under Medicare."

After telling about this "free gift" the solicitation adds by way of P.S. that the administrator of the trust is "the prestigious and respected Union Fidelity Life Insurance Company." A toll free number is provided and customers are invited to "sample their fast, friendly service."

The Nevada insurance commissioner wrote to Union Fidelity asking for information, saying:

This letter has been prompted by the increasing questions asked about the National Senior Citizen's Group Insurance Trust.

Over the past few months our Nevada residents have been swamped by requests to become insured under the group trust. After my review of the materials sent to entice the elderly to purchase, I am convinced the coverage is poor and the information supplied the prospective insured is deceptive, misleading and less than truthful.

Please supply this Division with a copy of the policy, certificate and information about the trust. *How* was the trust formed, *who* are those involved, *where* is it located and *what* does it do for the elderly other than supply group insurance.

The Department came to the conclusion that the trust was problematic but felt that legally there was little they could do to keep policies from coming into their State.

Examples of mail order advertising materials follow. Note the typical use of target population celebrity endorsement: group trusts; the official Government look on certain pages; and misleading newspaper scare headlines planted to promote insurance sales.



NATIONAL EXECUTIVE OFFICES  
TREVOSSE, PENNSYLVANIA 19047

*"Devoted to the insurance needs  
of people 65 and over."*



Dear Friend,

Folks like us . . . age 65 or over . . . have got to be concerned. Medicare has raised your deductibles again effective January 1, 1979. This time it's an 11% hike . . . and it's the 11th year in a row. The fact is, Medicare costs have gone up more than 50% in the past 3 years. That means more money out of your pocket the next time you're hospitalized.

When you join me as a member of the National Senior Citizens Group Insurance Trust, you won't have to worry about these higher Medicare deductibles. That's because you'll be eligible to enroll in the National Senior Citizens Group Trust Insurance Supplement to Medicare. This important coverage gives you the financial protection that Senior Citizens need . . . and gives it to you at **GROUP RATES**. The coverage **pays all** Medicare In-Hospital deductibles you now must pay out of your own pocket. This includes the initial deductible which the federal government increased to \$160.00 on January 1, 1979.

The Supplement to Medicare pays benefits direct to you . . . or to anyone you choose . . . regardless of what other coverage you may have. There are no costly co-payments and no coordination of benefits. Best of all, the National Senior Citizens Group Insurance Trust has increased the benefits paid by their Supplement every time the Federal Medicare Program has increased deductibles. Yet . . . **they've never increased rates.**

I'm proud and pleased to be a member of the National Senior Citizens Group Insurance Trust. As someone who shares and understands your concerns about rising hospital costs, I urge you to take advantage of this invitation to enroll in our Supplement to Medicare and to protect yourself from the increased Medicare deductibles. You'll be happy to know your coverage will be underwritten by the nationally known Union Fidelity Life Insurance Company . . . a company with an impressive record for prompt, courteous claims payment and a TOLL-FREE Hotline which brings expert service as close as your telephone.

Act now to give yourself this important protection.

Sincerely,

Arthur Godfrey

P.S. You may see other Medicare Supplements that look as good at first glance . . . but examine them closely. They may make you pay the \$160.00 initial deductible yourself. This Supplement pays that \$160.00 plus all the In-Hospital Medicare Deductibles. I've enclosed a copy of the Trust's official newspaper The Senior Citizens Sentinel. Hope you enjoy it!

**ENROLLMENT**  
is now open for


Frank Simmons

in the 1173510

**NATIONAL SENIOR CITIZENS GROUP INSURANCE TRUST**

DEVOTED TO THE INSURANCE NEEDS OF PEOPLE AGES AND OVER

1 Corporation and Subsidiaries of Group-Term Life Insurance Company



The National Senior Citizens Group Insurance Trust was created to provide members with ways to meet today's cost of medical care with the right kind of insurance coverage at Low Group Rates. Members may get a Medicare Supplement Insurance Plan at Low Group Rates. Best of all, you pay nothing to belong... there are no membership fees, dues or costs.

DETACH ENROLLMENT FORM ALONG BROKEN LINE

**ENROLLMENT FORM**

NATIONAL SENIOR CITIZENS GROUP INSURANCE TRUST  
MEMBER BENEFITS DIVISION  
UNDERWRITERS AND ADMINISTRATORS OF GROUP-TERM LIFE INSURANCE

FORM NUMBER: 155232-3

NAME: **Frank Simmons**

ADDRESS: [Redacted]

CITY: [Redacted] STATE: [Redacted] ZIP: [Redacted]

DATE OF BIRTH: [Redacted] AGE: [Redacted] SEX: [Redacted]

I ALSO WISH TO ENROLL MY SPOUSE: [Redacted] DATE OF BIRTH: [Redacted]

I understand that my coverage under *Home Policy Plan* will become effective when issued, and that my condition for which I or my spouse have received medical treatment or surgery in the past will not be covered under my coverage. You have to have a doctor's report.

SIGNATURE: [Redacted] DATE: [Redacted]

*Receipt & Guarantee*

Number: 1173510 Date Mailed:

Received From: Frank Simmons

Amount Mailed: NO MONEY REQUIRED

We will mail your policy to your home. If you are insured, we'll send you your bill within 21 days. Even after you pay your premium, we guarantee to underwrite your policy. If we are not completely satisfied with your coverage, just return your policy within 30 days and a refund check will be sent to you immediately.

MEMBER BENEFITS DIVISION  
NATIONAL SENIOR CITIZENS GROUP INSURANCE TRUST, 3700 N. W. 11th St., Ft. Lauderdale, FL 33309



You will receive this important MEMBERSHIP CARD

If you're eligible, you'll be a member of the National Senior Citizens Group Insurance Trust. We'll mail it to your home or hospital to advise how you have to participate in coverage.

IT'S ALWAYS BICKER AND SOMETHING ELSE... Take a look at the **NEW OFFER** below. Also see what the **NATIONAL SENIOR CITIZENS GROUP INSURANCE TRUST** offers you in protection against catastrophically rising costs of hospital care and your increased Medicare charges. Medicare deductibles went up another **11% January 1, 1979**. You pay that extra amount.

That's why we have reserved a spot for you in the **new** that's protection. **THEMERS** of **1979** over 25.

**THIS IS YOUR PERSONAL RESERVATION NUMBER.**

1173510

If you join before **midnight, February 15, 1979**, you are eligible for your **FREE** Medicare Supplement Card. And you can take advantage of the **FREE** Medicare Supplement Plan with these 5 special features:

- **SAVE** all in-hospital deductibles you normally pay yourself.
- **ONE** rate for all ages 65 and over.
- **FREE** benefits in addition to any benefits received from Medicare or any other insurance.
- **SAVE** **25%** on **CO** as you get older.
- **PAID** the Cash Benefits direct to you or anyone you wish.

Frank Simmons

This is the Medicare Supplement that pays you the **FREE** in-hospital deductibles plus all the in-hospital deductibles. Others may look at you at first glance, but realize that **FREE** they may make you pay that **FREE** yourself.



**Free...**  
If You Enroll By Midnight  
February 15, 1979

The official National Senior Citizens Group Insurance Trust Medicare Reference Card will be yours free. You'll receive it the day you register. This special card is available only to those who enroll by midnight, February 15, 1979. After Medicare pays and doesn't pay when you're hospitalized, you'll know of basic, the handy, we'll be there to help you. Contact us for more information. **FREE** card you receive for your card.

**HOW TO ENROLL**

1. Fill out the short Enrollment Form and sign at the bottom.
2. Detach and mail your Enrollment Form in the envelope provided.
3. Detach and keep your guarantee with your financial records.

**REMEMBER, SEND NO MONEY NOW!**

Both You and Your Spouse Can Be Covered! If you're pleased with the coverage, you may purchase it at the low rate shown below.

YOU WILL ENJOY THIS LOW GROUP RATE **\$6.40** a month per person

TLC 370510 BA24-4L FL

# The National Senior Citizens Group Plan Pays All In-Hospital Deductibles You Normally Pay Yourself

## This Medicare Reference Chart

Shows how the National Senior Citizens Group Insurance Trust Medicare Supplement works hand-in-hand with Medicare.

### You Get Valuable Inflation Protection, Too . . .

As you know, the Medicare Deductibles — the cost you pay for hospital care — went up another 7% as of January 1, 1978. This 1978 increase, along with the all-time increases, has raised your out-of-pocket expense a total of over 50% in just three years.

This is the principal reason why the National Senior Citizens Group Insurance Trust Medicare Supplement has increased its benefits each time Medicare Deductibles went up — with never an increase in premium.

	WHAT IN-HOSPITAL MEDICARE PAYS — AND WHAT YOU MUST PAY	WHAT THIS SUPPLEMENT PAYS YOU
<b>DAYS 1-90 OF BENEFIT PERIOD</b>	<b>MEDICARE PAYS</b> all covered hospital inpatient (except Skilled Nursing Facility) care during 90 days — except the \$100.00 Initial Deductible and the first 3 days of inpatient.	<b>WE PAY YOU</b> the \$100.00 Initial Deductible. We also pay you for your first 3 days of inpatient, up to \$25.00 per day.
<b>DAYS 91-90 OF BENEFIT PERIOD</b>	<b>MEDICARE PAYS</b> all but \$40.00 a day of the hospital charges.	<b>WE PAY YOU</b> the \$40.00 a day. We pay you for hospital care during this entire 90-day period, a total of \$7,200.00.
<b>DAYS 91-156 OF BENEFIT PERIOD</b>	<b>MEDICARE COVERAGE ENDS</b> unless you use your Lifetime Reserve. For the period of 90 days coverage you can use only once.	<b>WE PAY YOU</b> \$50.00 a day while you use your Lifetime Reserve. We pay you the amount evenly covered during the hospitalization during the entire 90-day period — totaling \$4,500.00.
<b>DAYS 157 AND AFTER</b>	<b>MEDICARE PAYS NOTHING</b> — your hospital benefits run out.	<b>WE PAY YOU</b> 100% of all your eligible hospital charges up to \$100.00 a day, up to \$50,000.00. We even pay for a private room if approved by Medicare.

This Medicare Supplement Benefit Period begins with the first day you are hospitalized. It continues for as long as you're confined and for 90 days after you've been released from the hospital or Extended Care Facility. You enter a new benefit period immediately the next time you're hospitalized.

This Medicare Supplement (Form A3698B) is not connected with the U.S. Government or Federal Medicare Program. It pays the deductibles that the Federal Medicare Program doesn't.

## The National Senior Citizens Group Insurance Trust Medicare Supplement is Underwritten And Administered By Union Fidelity Life Insurance Company

Union Fidelity is the established, nationally known specialist in insurance for folks 65 and over. Their record is among the very best in the industry — with over 100 years of experience. Medicare Supplement claims processed within 5 working days. Union Fidelity pioneered "Instant Policyowner Service." Just dial their special TOLL-FREE number 800-525-5758 and a trained specialist will be on the line to give you immediate assistance.

## It's A Fact:

Our Plan . . .

- Offers One Rate To All
- Guarantees Your Coverage For Life . . . As Long As You Pay Your Premiums When They Are Due And The Master Policy Remains In Force.
- Pays You In Addition To Any Benefits Received From Medicare or Any Other Insurance
- Our Rates do Not Go Up as You Get Older

**Act Now!** Fill Out The Enrollment Form On The Other Side . . . No Risk Or Obligation!

Remember — There Are No Dues or Membership Fees Ever!

## YOUR QUESTIONS ANSWERED

1. Can the insurance company cancel my coverage at some time?

As long as you pay your premium on time and continue membership, **NO INDIVIDUAL MEMBER CAN EVER BE CANCELLED** unless you have commits remaining. If and when the insurance company cancels or drops your individual policy — this is not an end job. You may desire to your health changes. Premiums can be lowered or renewed denied only if the same individual is taken on an insurance elsewhere under the Master Policy (A 3698B).

2. Will I get paid to any hospital I choose?

Any hospital that is recognized by Medicare Law in 1966 Title XVIII is also recognized by us. In fact, even if you're confined in a hospital that doesn't participate in the Medicare Program, the National Senior Citizens Group Insurance Trust Medicare Supplement still pays benefits to you. Facilities such as T.C. Sanatoriums, drugs or alcoholic clinics are not covered, nor are facilities where there is no obligation to pay in the absence of insurance, mental institutions, nursing homes, convalescent or extended care facilities. Federal Medicare does cover confinement in a mental institution.

3. Suppose I no sooner get my insurance and I land in the hospital — am I covered?

When your Insurance Certificate is entered it will be in force as of the effective date. So if you enter the hospital for a covered condition, you will be immediately eligible for benefits. You just never know when accident or illness will strike you or your spouse. We've seen it happen to people the very day their coverage commences.

4. Does the plan pay all benefits direct to me?

You decide. All checks are made out directly to you. For your convenience, we will even make payment to your hospital or doctors if you request it. This benefit will be yours starting on the day you're hospitalized.

5. All insurance plans have exclusions. What are the things this plan doesn't cover?

1) **PRE-EXISTING CONDITIONS** (any sickness or injury medically advised or treated or for which distinct symptoms were evident prior to your certificate's effective date). **UNLESS YOUR CERTIFICATE HAS BEEN IN FORCE SIX MONTHS.** 2) Loss covered under Workmen's Compensation or Occupational Disease Law, or services rendered by any federal or state agency when you do not have to pay or any treatment rendered which is not considered necessary by competent medical authorities. 3) Loss due to war, acts of war, mental disorders, self-inflicted injuries, alcohol or narcotics unless administered under the advice of a physician, custodial care. 4) DC or state owned institutions in which the majority of patients are under treatment for mental illness or tuberculosis. 5) Does not supplement Medicare Part B.

6. Do I have to send in a full first premium to apply for coverage?

Send no money just your Enrollment Form. You'll receive your Medicare Supplement Plan by return mail. Complete the Plan up close for a full 30 days. Then decide for yourself with no pressure from anyone. To start your coverage, simply pay your first premium within 31 days of the effective date. Otherwise, let the 31 days go by — you'll have no coverage and nothing. There's no risk to you.

# It's Front Page News... an 11% hike in your Medicare Costs starts Jan. 1, 1979



*It means the out-of-pocket expenses for the 27 million Americans on Medicare have gone up again... for the 11th straight year. Over the last three years the amount you must pay has gone up more than 50%. But don't worry... Our Medicare Supplement Benefits have been raised automatically to meet the increase... with no increase in rates!*

## SOMETHING SPECIAL FOR VETERANS

Although it has not been criticized to the same extent, another company, the National Home Life Assurance Company of Valley Forge, Pennsylvania, has established a similar trust relating to veterans, called the American Veteran's Group Insurance Trust. In huge letters its brochures proclaim "Notification of Cash Benefits to Veterans." The language continues:

- Congratulations, this temporary membership card, when signed by you, shows that you qualify for membership in the Trust and that you have completed and mailed the enrollment form for this Group Hospital Cash Plan for Veterans.

The brochure promises a free gift plastic card for your wallet, personalized with your name on it. In huge letters beneath the American Eagle, the solicitation says:

This Offer For Veterans. Veterans are given the opportunity to select from Plan A or Plan B. The former pays up to \$1,200 a month cash and the latter up to \$900 a month. Visa or Master Charge are acceptable if you don't have the cash. Rates for Plan A are \$6.60 to \$15.72 a month depending on age of the applicant and rates under Plan B are \$5.18 to \$12.02 per month.

Those who apply before the deadline are also eligible for a golden bronze medallion, a relief sculpture of Iwo Jima.

The Veterans' Administration was so concerned about this kind of solicitation that they issued a press release to warn the public that there was no affiliation between the brochures and the Veterans' Administration. The DAV Hotline of December 1977 read:

The Veterans' Administration is cautioning veterans that there is *no connection* between the VA and insurance protection being offered by the *American Veterans Group Insurance Trust* through the National Home Life Insurance Company, Valley Forge, Pa.

According to *Dorothy Starbuck*, VA Chief Benefits Director, the advertising materials distributed by this company carry a return address directed to "Administrator" which may lead recipients to believe the coverage offered is sponsored through the VA. The company is also adding to the illusion that the program is VA-sponsored by distributing a pamphlet entitled, "A Guide to Veterans Benefits."

Starbuck warns veterans *not to confuse* the American Veterans Group Insurance Trust with the Veterans Group Life Insurance or Servicemen's Group Life Insurance programs which are supervised by the VA and operated by the Servicemen's Group Life Insurance, Newark, N.J.

The VA *strongly recommends* that anyone wishing further information about American Veterans Group Insurance Trust should get in touch with the Insurance Commissioner in the State where they reside.

*Repeat . . .* there is *no affiliation* between the Veterans Administration and the American Veterans Group Insurance Trust.



## American Veterans Group Insurance Trust

TRUSTEE: United Missouri Bank of Kansas City NA  
 UNDERWRITER: National Home Life Assurance Company  
 ADMINISTRATOR: National Liberty Marketing, Inc., Valley Forge, Pennsylvania

### Great News for Veterans!

You qualify for up to \$40.00 a day cash benefits. **REGARDLESS** of any other insurance benefits you may be getting!

These cash benefits are yours at LOW GROUP RATES when you enroll in this group hospital plan for Veterans.

**IF YOU ARE NOT  
 A VETERAN, PLEASE  
 PASS THIS LETTER ON  
 TO A FRIEND WHO IS.**

Dear Veteran,

Before you do anything else, detach the enclosed Membership Card. Sign it at once and place it in your wallet for safekeeping.

After you have mailed the enclosed Enrollment Form, this temporary card, when signed by you, shows that you qualify for membership in the American Veterans Group Insurance Trust and that you have enrolled in this Group Hospital Cash Plan for Veterans. With this plan you and your family can collect valuable cash benefits ...

... up to \$40.00 A DAY CASH paid direct to you, unless you ask otherwise, when you are hospitalized for a covered accident or illness.

You receive these cash benefits without regard to any other insurance coverage you may have. As with G.I. Bill benefits, the money you receive under this plan is not taxable, according to the IRS. And you can spend it any way you wish.

You are guaranteed acceptance in this plan if you are an honorably discharged Veteran. You did your part for your country. Now it's time that something should be done for you!

As a Veteran myself, I urge you to give serious consideration to this opportunity to obtain hospital cash protection at low group rates.

### THE FACT IS, YOU HAVE EARNED THESE BENEFITS.

You and I and our buddies in uniform were the best America had. We were there when they needed us. Coming from all walks of life. And setting an example for other Americans. So we believe Veterans like us deserve a break -- and should be rewarded with low insurance rates. That's why this Hospital Cash Protection is offered to you through the American Veterans Group Insurance Trust, a service exclusively for honorably discharged veterans

and their families, not affiliated with any agency of the U.S. Government. The protection is underwritten by National Home Life Assurance Company, Valley Forge, Pennsylvania.

A GOLDEN BRONZE MEDALLION --  
YOURS AS A FREE GIFT

In your honor, the American Veterans Group Insurance Trust is distributing an exclusive Veterans Commemorative Medallion to its new members. Struck in polished golden bronze by the nation's oldest private mint, the Medallion shows the flag raising at Iwo Jima, one of our country's proudest moments. The Medallion is to be your gift, without cost or obligation. As a veteran, you deserve it!

CHECK THE MANY VALUABLE FEATURES OF THIS GROUP PROTECTION:

1. As a qualified Veteran your acceptance is guaranteed. You cannot be turned down for any reason!
2. You can examine this group plan at absolutely no risk because you send no money now and you have the right to examine your Certificate of Coverage for 21 days before you decide.
3. Cash benefits are paid regardless of any other coverage: G.I. Benefits, V.F.W. or American Legion plans, any government pension plans, Medicare, disability payments you may receive, or any other company's coverage.
4. You collect as long as you are hospitalized. A month, a year, even for life.
5. This insurance is not just for you alone, but for your family, too, if you wish.
6. Cash is paid to you personally. Not to a hospital or doctor, unless you wish it that way.
7. The money you receive is not subject to income tax, according to the I.R.S. (Spend it as you see fit.)
8. Your protection cannot be cancelled because of the number of claims you have had, or your age. As long as you pay your premiums and the master contract (MP140) for this Group Plan is in force, your coverage is guaranteed.
9. You cannot be singled out for a rate increase. As a member of this group plan for Veterans, your rate can be changed only if rates are changed for everyone of your class insured under this group insurance policy.
10. And check this biggest feature of all:  
You are entitled to LOW GROUP RATES ... because you and countless other ex-Servicemen are buying insurance together as a group. So naturally, you're entitled to group rates!

**THESE ARE THE CASH BENEFITS  
YOU RECEIVE UNDER PLAN A**

Your protection starts from the very first day for covered accidents and after three days for covered illness.

If you're under 65, you collect \$40.00 a day cash when hospitalized for covered accident or sickness. And there are no cash limits on how much you can collect!

If you're 65 or over, this group plan pays in addition to Medicare. During the first three months of any covered hospital stay-- when Medicare is paying you -- you collect \$20.00 a day cash. Starting the fourth month; if you're still hospitalized, you collect the full \$40.00 a day ... until you're safely out of the hospital!

If your wife or kids have coverage and are hospitalized, you get more cash: up to \$40.00 a day for your wife. \$24.00 a day for your youngsters. One small additional premium covers all your kids, even if you have enough for your own football team!

**MORE CASH BENEFITS FOR YOU:**

In addition to all the cash benefits I've already mentioned you can also collect up to \$10,000.00 for accidental loss of limbs or eyesight. You'll also collect \$160.00 a day cash for accidents that hospitalize husband and wife at the same time while both are under age 65. There's also \$40.00 a day maternity benefits and \$16.67 a day cash for a nurse at home ... and even a Waiver of Premium benefit.

**HERE'S WHY YOU NEED THIS EXTRA PROTECTION.**

Like most people, you probably already have some insurance coverage. Such as a company Major Medical or Medicare. But if you think your bill worries are over, you may be making the mistake of your life.

The cost of getting sick or hurt has skyrocketed. The average cost per patient to a community hospital is now more than \$173.00 a day according to the American Hospital Association. That brings the average cost per patient stay to over \$1,330.00!

Many good plans don't pay for medicines ... Surgery ... Specialists ... Nursing care ... Transfusions ... A private room ... And more. Also, they may have benefit limits. As a result, people like yourself often end their hospital stay with big, unpaid bills.

That's the beauty of this group coverage for Veterans. That check from National Home will help pay your unpaid bills.

**WHAT YOU ARE NOT COVERED FOR:**

These are the exclusions. You are not covered for conditions caused by: any sickness or injury for which medical advice or treatment was given or for which distinct symptoms were evident, during the one-year period before the effective date of the coverage.

(These conditions are not covered until one year after your coverage is in force.) War or any act of war; the use of narcotics or intoxication; any mental disease or disorder; pregnancy, unless you have chosen the optional Maternity Benefit. You are not covered for care in a nursing or convalescent facility or any facility not defined as a hospital in your Certificate.

HERE'S HOW TO GET YOUR CERTIFICATE.

It's easy to get your certificate with the enclosed Enrollment Form. Here's all you do:

1. Detach the stamp indicating your branch of service and affix it in the space provided.
2. Check the plan that best suits your needs, then complete the brief Enrollment Form.
3. Detach and mail the Enrollment Form in the postage-free envelope provided. Send no money now.

USE YOUR 21-DAY EXAMINATION PRIVILEGE!  
SEND FOR YOUR CERTIFICATE TODAY!

There's one thing we want to make absolutely clear: when you send for your Certificate, you're not "signing up". In fact, don't send money to enroll. All you're doing is asking to examine our coverage. If you decide you don't like it, you will not have coverage, and that will be that. We don't want you to pay a nickel unless you're completely satisfied with the plan. On the other hand, if you are satisfied with the plan, just send in your low first month's premium within 21 days of the Effective Date shown on your Certificate and you'll have up to \$40.00 a day cash protection.

Because I'm convinced that this plan represents a valuable opportunity for veterans, I've taken the liberty to include an extra enrollment form for you to pass on to a fellow veteran. When you give the form to another veteran, you'll be giving him the same opportunity for his family that you have for yours.

Remember -- as an honorably discharged Veteran, you cannot be turned down for this coverage because of your age or for any other reason. And as I said, you don't pay a cent unless you're 100% satisfied with the plan.

Sincerely,



Thomas D. Jewell  
For The American Veterans  
Group Insurance Trust

TDJ:fla  
LH1194

P.S. Send for your Certificate today ... there's absolutely no risk or obligation on your part. And don't forget -- to receive your exclusive Veterans Medallion, you must reply by the Medallion Deadline Date.

T.D.J.



Act before Medallion Deadline Date to receive this exclusive Veterans Commemorative Medallion honoring you, the American Veteran.

As an honorably discharged U.S. Veteran, you are entitled, Mr. J. Seay is a guide source Medallion with your membership in the American Veterans Group Insurance Trust.

The Medallion honors you and your fellow veterans for the priceless service performed for our country. It is your highest mark of obligation. As you respond by the Medallion Deadline Date, 7:00 A.M., February 11, 1978, you will receive a commemorative Medallion. The Medallion bears a relief sculpture of the American flag design. On the reverse side is the Medallion, symbol of our country's great history.

# Notification Of Cash Benefits To Veterans



As an honorably discharged Veteran, you qualify for participation in the American Veterans Group Insurance Trust and to enjoy cash benefits of up to:



## \$40.00 A Day

AT LOW GROUP RATES

### CONGRATULATIONS

This Temporary Membership Card, when signed by you, shows that you qualify for membership in the Trust and that you have completed and mailed your enrollment form for this Group Hospital Cash Plan for Veterans. After you've sent in your form, carry the card in your wallet. When you are insured, you will receive a personalized Membership Card embossed with your name and Certificate number.

### THIS OFFER PREPARED FOR:

Mr. J. Seay  
2702 High Hope Rd.  
Lake Worth, FL 33460

IT'S EASY TO GET YOUR CERTIFICATE. FILL OUT ENROLLMENT FORM BELOW, DETACH AND MAIL TODAY. SEND NO MONEY NOW.

Medallion Deadline: Response needed by February 11, 1978

### AFFIX PROPER STAMP IN BOX AT RIGHT TO INDICATE BRANCH OF SERVICE



AS AN HONORABLY DISCHARGED VETERAN, YOU CANNOT BE TURNED DOWN FOR THIS PROTECTION

### VETERANS: USE THIS FORM TO ENROLL FOR CASH BENEFITS

#### 1. Affix the stamp indicating your branch of service here.

AFFIX STAMP HERE

2. Check your rate base each year.
- PLAN A \$40.00 A DAY CASH
- PLAN B \$30.00 A DAY CASH

Send this form to the Medallion office to get your cash benefits.

#### 3. Complete and sign Enrollment Form at right. Send no money now.

4. Detach and mail this entire section in postpaid envelope provided.

NOTE: If you are not in the Medallion office to get your cash benefits, you will receive a personalized Membership Card embossed with your name and Certificate number.

American Veterans Group Insurance Trust  
P.O. Box 20, Winter, Florida 32782

Indicate that you are a Veteran and sign this form. We will mail you your cash benefits immediately.

PL-227 010 NATIONAL HOME LIFE ASSURANCE CO.  
90943316

A Mutual Stock Company

ADMINISTRATIVE OFFICE: SALLEE POND, HONOLULU, HAWAII

Branch: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Your Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

1. I want cash benefits for myself.

2. I want cash benefits for children and possibly benefits, dependent on my dependent's income.

3. I want cash benefits for my dependent's income.

4. I want cash benefits for my dependent's income.

5. I want cash benefits for my dependent's income.

6. I want cash benefits for my dependent's income.

7. I want cash benefits for my dependent's income.

8. I want cash benefits for my dependent's income.

9. I want cash benefits for my dependent's income.

10. I want cash benefits for my dependent's income.

11. I want cash benefits for my dependent's income.

12. I want cash benefits for my dependent's income.

13. I want cash benefits for my dependent's income.

14. I want cash benefits for my dependent's income.

15. I want cash benefits for my dependent's income.

16. I want cash benefits for my dependent's income.

17. I want cash benefits for my dependent's income.

18. I want cash benefits for my dependent's income.

19. I want cash benefits for my dependent's income.

20. I want cash benefits for my dependent's income.



# Enjoy low group rates for Veterans.



## Your Combined Purchasing Power Makes the Big Difference.

Here's our way of doing something extra  
to help the American Veteran.

As an honorably discharged Veteran, you did your part for your country. Now, the American Veterans Group Insurance Trust is doing something for you. Through the combined purchasing power of thousands of Veterans, you can now help yourself to a group hospitalization plan that fits your special needs. National Home Life Assurance Company, one of the leading companies in the field, is proud of the veterans who have served in America's Armed Forces. That's why National Home has underwritten this plan for veterans at low group rates. This is the least expensive kind of insurance rate offered.

Today, over 1,400,000 people have National Home protection under various group and individual health and accident plans. And because you are a veteran, you now are eligible for this plan of low group rates.



Illustration: Home Life Assurance Company, National Home Life Assurance Company, National Home Life Assurance Company, National Home Life Assurance Company

### THREE-WAY PLEDGE TO VETERANS

#### 1. Pricing Protection

We guarantee not to charge you out for a rate increase because of how old you become . . . or how many claims you have. Your rates can only be changed if rates are changed for everyone in your class covered under the group insurance policy.

#### 2. Guaranteed Coverage

As long as you pay your premiums and the double contract for this group insurance plan is in force, we guarantee that your insurance cannot be canceled, no matter how many claims you have, or how old you become.

#### 3. No-Risk 21-Day Examination

We will send you certificate by mail. Examine it carefully. Think it, if you wish, to any friend or neighbor. If you decide not to keep it, you first month's premium within 21 days, you will not have coverage and you won't owe us a cent. Meanwhile, if you decide to keep your protection and send in your first month's premium within 21 days of the Effective Date, you'll be protected while making your decision.

### THIS OFFER FOR VETERANS



COMPLETE THE OTHER SIDE, DETACH ALONG PERFORATION AND MAIL TODAY

NAVY  
BRANCH OF SERVICE  
STAMP

ARMY  
BRANCH OF SERVICE  
STAMP

MARINES  
BRANCH OF SERVICE  
STAMP

AIR FORCE  
BRANCH OF SERVICE  
STAMP

NATIONAL GUARD  
BRANCH OF SERVICE  
STAMP

COAST GUARD  
BRANCH OF SERVICE  
STAMP

DETACH STAMP INDICATING YOUR BRANCH OF SERVICE  
AND AFFIX IN SPACE PROVIDED NEXT TO ENROLLMENT FORM ON OTHER SIDE.

## CANCER POLICIES TO CATHOLICS

Union Fidelity has also established the so-called **United Catholic Group Insurance Trust**. This trust was used to promote an insurance policy to protect Catholics against cancer. Vermont Commissioner Stewart Ledbetter said, "There is so much objectionable and misleading about the promotional techniques as well as the basic coverage that one doesn't know where to begin in condemning it." He added:

The promotional campaign was terminated through the efforts of this Department working in conjunction with the Arch Diocese of Burlington over the strenuous objections of attorneys for Union Fidelity Life Insurance Company. Thirty-five thousand copies of promotional literature prepared for insertion in the *Vermont Catholic Tribune* were destroyed as a result of our intervention.

The Commissioner asked for any help or data which would aid his office "to eliminate the most onerous of such policies offered in the State of Vermont."

The brochure uses the huge white letters against a funereal black background saying:

The Same Thing That Happened to Babe Ruth, Nat "King" Cole, Walt Disney, Sophie Tucker, Gary Cooper, Babe Zaharias, Spike Jones, Chet Huntley, Jack Benny, Vince Lombardi, and Walter Winchell, Could Happen to You.

And in even larger type, worthy of the report of the attack on Pearl Harbor, the word "Cancer" appears.

The ad then offers the good news in only slightly smaller print:

As a Catholic, you are now eligible for important financial protection against the tremendous cost of cancer. Join the United Catholic Group Insurance Trust.

In smaller print, it promises the usual free gift:

Join before September 30 and receive a beautiful Saint John Neuman Commemorative Prayer Plaque—Absolutely Free.

In tiny print, the brochure says that it is an advertising supplement designed to appear in the following newspapers all across the United States:

Advertising supplement to: Inland Register, Westmont World, Catholic Register, The Catholic Voice, Catholic Messenger, Telegraph Herald, The Globe, St. Louis Review, Catholic Commentator, Morning Star, Clarion Herald, The Spirit, Times Review, The Messenger, New World, Catholic Post, The Message, The Voice, Church World, The Catholic Spirit, Vermont Catholic Tribune, The Catholic Register, Lake Shore Visitor, The Catholic Accent, Catholic Witness, The Catholic Standard & Times, The Pittsburgh Catholic, Arlington Catholic Herald.

The brochure goes on to invoke the usual scare language:

The celebrities mentioned and millions of others, in fact, one out of every four people, two out of every three families, will be affected by this horrible disease.

The plan then tells Catholics that they can get "the \$200,000 United Catholic Group Insurance Trust Cancer Plan." There are the usual promises of extended hospital benefits up to \$10,000 a month or \$333.33 a day. Of course, the only way a person could receive the \$200,000 that is promised is to be hospitalized consecutively for about a year. As noted in the Massachusetts report summarized in Section V, most people receive no benefits at all under this kind of a policy. Moreover, the average claim for those who do collect is about \$1,200—a far cry from the boldly promised \$200,000. This reality helps to explain how the policy can be offered for \$6.15 a month or \$9.40 a month for a family.

A special note to senior citizens tells them that benefits are paid to them over and above what they get from Medicare: implying, perhaps, that the senior won't lose his or her Medicare coverage if they buy this policy. The brochure extols the buyer to "Act Now" with the warning that "you can't be covered once cancer strikes," adding, "it's a decision that shouldn't wait even one day longer." As if this fear tactic were not impetus enough, the pamphlet says:

If it takes you 10 minutes to read this brochure . . . according to American Cancer Society statistics, approximately 13 new cases of cancer were diagnosed.

The usual toll free hotline is provided for those who feel that return mail is not fast enough to take advantage of the offer presented.

There are many conditions and exceptions which limit the value of the policy but there are two which may stand in the way of the customer's ability to buy it in the first place. The customer must certify that he has never had cancer before in any form and that he is a member of the Roman Catholic Faith. The brochure is liberally sprinkled with the sign of the cross and frequent exhortations, such as:

Every member of the Catholic Community has an obligation to protect his or her physical well-being as well as his or her spiritual health . . . We help meet the insurance needs of Catholic families and individuals.

Always, there is the reminder to ignite the spark of fear:

A new case of cancer is diagnosed every 46 seconds. Don't delay your decision on this important matter.

The brochure also adds testimonials, such as:

Here is what E. M. Gallo, N.J. says, . . . The processing of my claim was very satisfactory. Your check arrived before my doctor bill. Thank you for your service.

It also says in bold letters: "Benefits are not subject to State or Federal income tax" to make the customer believe he will receive some super-valuable windfall. It adds that there is guaranteed acceptance for Catholics implying that others will not be saved.

It is easy to see why the Vermont commissioner was outraged. Cancer insurance sales are definitely the most onerous of all mail order insurance sales. It is not only the sales practices that are offensive but the failure to provide reasonable economic value to the insured. Union Fidelity is a good case in point. In 1976 Union Fidelity had a loss ratio of about 45 percent for all kinds of insurance. According to the U.S. General Accounting Office, some 20 percent of their business involves the sale of cancer insurance through the mails. GAO also informed the Committee that Union Fidelity returned only 19 cents on each cancer insurance premium dollar back to their insured in the form of claims. Put another way, Union Fidelity keeps 81 percent of the money paid in while promising Catholics, senior citizens and others that it is concerned about their welfare and will pay \$200,000 when cancer strikes. The 81 cents on each premium dollar is made up of two factors: administrative costs and profit. It should be obvious that it costs little to prepare and print these kinds of brochures and have them entered as supplements in the listed newspapers. There are no agents to pay so the only other remaining costs would be the cost of processing claims, which again is a comparatively small item. This analysis leads to the assumption that Union Fidelity may be making a profit of 60 cents or more on each dollar in premiums that are paid in for cancer insurance.



**AN IMPORTANT MESSAGE FROM  
THE ADMINISTRATOR OF  
THE UNITED CATHOLIC GROUP  
INSURANCE TRUST CANCER PLAN**

Every member of the Catholic Community has an obligation to protect his or her physical well-being as well as his or her spiritual health. Whatever your age, regular medical check-ups are an important part of a sensible living pattern.

You don't like to think about it but we now face a Cancer crisis. 54 million Americans, healthy today, will be hit by Cancer. That's 1 out of every 4, with a new case diagnosed every 46 seconds. 2 of every 3 families will know the heartache of Cancer. These are facts from the American Cancer Society.

You trust your doctor to care for your medical problems. But you, and you alone, have the responsibility for handling the money burdens that accompany illness. According to the American Cancer Society, Cancer treatment costs the American public \$3 billion a year. That's \$3,000,000,000! Most families simply can't meet the cost of Cancer treatment alone. They don't have the money.

That is why the United Catholic Group Insurance Trust was formed. We help meet the insurance needs of Catholic families and individuals. The only service we offer is good insurance like this Cancer Plan. We have no dues and never solicit contributions from our Trust members. If a Catholic wants insurance service, we are here to serve!

The Cancer Plan described in this brochure is protection you should consider . . . today. We ask that you enroll . . . and send no money. After receiving your certificate you are under no obligation to pay the first month's premium. If you do within 21 days, you are covered from the effective date. If not, you owe nothing.

A new cancer case is diagnosed every 46 seconds. Don't delay your decision on this important matter. Send your enrollment form today.

Sincerely,

*J. P. Cassidy*  
Administrator

**ENROLL BEFORE SEPTEMBER 30, 1977  
AND RECEIVE A BEAUTIFUL METALLIC  
SAINT JOHN NEUMANN  
COMMEMORATIVE PRAYER PLAQUE  
ABSOLUTELY FREE!**

# CANCER.

**54 MILLION AMERICANS, LIVING TODAY,  
WILL EVENTUALLY GET CANCER. 2 OUT OF  
EVERY 3 AMERICAN FAMILIES WILL MEET  
THIS TERRIBLE DISEASE FACE-TO-FACE,  
SOONER OR LATER.**

**THESE STATISTICS COME FROM THE  
AMERICAN CANCER SOCIETY. THEY MEAN  
THAT 1 OUT OF EVERY 4 AMERICANS ALIVE  
TODAY WILL GET CANCER. THAT'S A NEW  
CASE DIAGNOSED EVERY 46 SECONDS.**

**BUT CANCER CAN BE CURED!**

**Early treatment saves lives! The best treatment  
available is the only treatment good enough for you  
and your family. But treatment is expensive. More  
expensive than most families can possibly afford.**

**THAT'S WHY WE OFFER  
CATHOLIC FAMILIES THIS  
\$200,000 CANCER PLAN**

Through the



**UNITED CATHOLIC GROUP  
INSURANCE TRUST**

Backed by the Union Fidelity Life Insurance Co.

If you are a Catholic, regardless of your age, we guarantee to issue you this \$200,000 Cancer protection. The only requirement is that you have never had cancer.

See the simple important facts inside about this plan that pays cash benefits to Catholic families struck by cancer. All benefits are paid in cash, in addition to any plan you already have . . . even Medicare!

Nobody knows who will get Cancer. We do know that 54 million Americans, living today, will be struck! That one fact alone should make you want to read this brochure . . . now.

Advertising supplement to: Inland Register, Westmont World, Catholic Register, The Catholic Voice, Catholic Messenger, Telegraph Herald, The Globe, St. Louis Review, Catholic Commentator, Morning Star, Clarion Herald, The Spirit, Times Review, The Messenger, New World, Catholic Post, The Message, The Voice, Church World, The Catholic Spirit, Vermont Catholic Tribune, The Catholic Register, Lake Shore Visitor, The Catholic Accent, Catholic Witness, The Catholic Standard & Times, The Pittsburgh Catholic, Arlington Catholic Herald.

**The same thing that happened to**

**Babe Ruth, Nat "King" Cole, Walt Disney,  
Sophie Tucker, Gary Cooper, Babe Zaharias,  
Spike Jones, Chet Huntley, Jack Benny,  
Vince Lombardi and Walter Winchell**

**Could happen to you**

**CANCER**

**As A Catholic, You Are Now Eligible For  
Important Financial Protection Against The  
Tremendous Cost of Cancer**

Join The



**UNITED CATHOLIC GROUP  
INSURANCE TRUST**

**See The Important Facts Inside . . .**



## WE WANT YOU TO COMPARE



An invitation from John Cassidy, Administrative Director for the United Catholic Group Insurance Trust

"When you buy insurance you want the greatest cash protection for the lowest possible price. That's why the United Catholic Group Insurance Trust was formed. Our message emphasizes the plain facts about our Plan. We invite you to compare our cash benefits . . . and Group Rates against any other plan.

"We offer first day coverage only. Your bills start on the first day, so should your benefits. We pay increased benefits for Cancer and Heart Attack. Also, folks 65 and over receive full benefits, — another big plus you don't see very often in other plans.

"As a Catholic, you are now eligible for this important Cash Protection. We spell out the facts for you on the following pages. Compare our benefits and LOW Group Rates. Be hard in your comparison then decide if the United Catholic Group Insurance Trust is best for you."

**GUARANTEED ACCEPTANCE  
NO CATHOLIC TURNED DOWN**

## The United Catholic Group Insurance Trust

### HOSPITAL CASH PLAN

Guarantees to Pay  
You Cash from the Very First Day

# \$40.00

A DAY

# \$1,200.00

A MONTH

**Cash paid direct to you from the very first day of hospitalization for covered accident or sickness.**

**Cash in addition to any benefits from any other plan, even Group or Medicare.**

**Full Cash benefits for folks 65 and over.**

**50% Cash increase for Cancer and Heart Attack.**

**Cash for both sickness and accidents.**

**Cash to spend any way you see necessary.**

**Cash paid for pregnancy or complications from pregnancy.**

**ENROLL BEFORE  
MAY 31, 1977  
AND RECEIVE A  
BEAUTIFUL METALLIC  
JOHN NEUMANN  
COMMEMORATIVE PRAYER PLAQUE  
ABSOLUTELY FREE**

**NO OBLIGATION** (vertical text on left)

**NO DEDUCTIBLES** (vertical text on right)

**GUARANTEED ACCEPTANCE**

SEE INSIDE FOR DETAILS →

UNITED CATHOLIC GROUP INSURANCE TRUST

**\$40.00 A DAY...\$1,200.00 A MONTH  
FIRST DAY CASH PROTECTION**

FOR BOTH SICKNESS AND ACCIDENT

**\$40.00 A DAY  
\$1,200.00 A MONTH**

Cash for every covered day from the very first day of hospitalization for both you and your spouse.

**\$40.00 A DAY  
\$1,200.00 A MONTH**

Even if you're age 65 or over, you get full benefits from the very first day of covered hospitalization for both you and your spouse — benefits do not reduce, ever!

**\$20.00 A DAY  
UP TO \$560.00**

Cash for hospital confinement for mental illness; work related injuries covered under Workmen's Compensation.

**\$160.00 A DAY  
\$4,800.00 A MONTH**

Double cash from the very first day when you and insured spouse are confined at the same time because of a covered accident.

**\$40.00 A DAY  
\$1,200.00 A MONTH**

Cash for hospitalization due to pregnancy and complications due to pregnancy, when All Family or Husband-Wife Plan is in force for entire period of pregnancy.

**\$20.00 A DAY  
\$600.00 A MONTH**

Cash from the very first day for each dependent child when they are hospitalized for a covered accident or sickness.

**SPECIAL FEATURE  
50% INCREASE FOR  
CANCER &  
HEART ATTACK**

**\$60.00 A DAY  
\$1,800.00 A MONTH**

Cash for every covered day from the very first day of hospitalization due to Cancer or Heart Attack.



**FREE GIFT!**

As a member of the United Catholic Group Insurance Trust you will receive a beautiful metallic John Newman Commemorative Prayer Plaque, if you enroll or mail your request by May 31, 1977.

**Here's what E.M. Gallo, N.J. says . . .**

*"... the processing of my claim was very satisfactory. Your check arrived before my doctor bill. Thank you for your service."*

BENEFITS ARE NOT SUBJECT TO STATE OR FEDERAL INCOME TAX

**SEND NO MONEY NOW**

See next page for more information.

## PROPOSED LEGISLATION

At the request of several State insurance commissioners, Chairman Claude Pepper introduced legislation which would help close this mail order insurance loophole. The bill is H.R. 2602 and is designed generally to end several different abuses in the sale of health insurance to the elderly. The bill is cosponsored by 265 Members of the House of Representatives. Section 11 of the bill reads:

Whoever knowingly advertises, solicits or offers for sale by mail, or knowingly deposits in the mail or sends or delivers by mail any insurance policy or policy certificates into any State in which said policy or policy certificates have not been approved by the State commissioner or superintendent of insurance shall be guilty of a felony and upon conviction there-of shall be fined not more than \$25,000 or imprisoned for not more than five years or both.

This language would require mail order insurers, including those who specialize in cancer insurance, to be subject to the same regulation as companies who use agents to make sales. Before they could sell their policies through the mails in any particular State, a company would first have to file its policies with the appropriate State insurance commissioner and receive his approval. Since introduction, the provisions of the bill have been warmly received by consumers as well as the State insurance commissioners. More than three-fourths of the commissioners polled by Committee questionnaire were strongly in favor of Section 11. In fact, some 38 or 76 percent of the nation's insurance commissioners said they welcomed language to help them regulate mail order Medicare supplementary insurance, 9 commissioners (18 percent) were opposed. Three (3) additional commissioners had no comment. See State by State tables at the end of this section. Commissioner Bill Gunter of Florida put it this way:

Too much of the so-called medi-gap supplemental insurance market is being solicited through the mails, insulated from State regulations.

Chairman Pepper's bill gives me and other insurance commissioners the power to police the sales. I urge each member of the subcommittee to act favorably on the bill and end what the distinguished Mr. Pepper so accurately described as a national scandal.

Mississippi Commissioner of Insurance George Dale added this:

I strongly support your suggestion to bar the sale through the mails of any policy which had not been approved by the state insurance commissioner of the state into which the policies are mailed.

The National Association of Insurance Commissioners formally endorsed this position in their January 1980 "Position Paper on the Baucus Amendment."

Obviously, this new legislation is needed and justified by the facts. It is hoped that the Congress will act to adopt H.R. 2602 in the near future.

## RESPONSES TO THE COMMITTEE'S OCTOBER 5, 1979

## SURVEY ON MAIL ORDER INSURANCE

Responses received as of January 1, 1980	Would you support the enactment of the language which would require mail order supplementary policies to be filed with the commissioner before being sold in the State?		Would you support the extension of this language to cover all health insurance policies instead of only medigap?	
	YES	NO	YES	NO
Alabama	X		X	
Alaska		No comment	No	comment
Arizona	X		No	comment
Arkansas	X		No	comment
California		X	No	comment
Colorado		X		X
Connecticut	X		X	
Delaware	X		No	comment
Florida	X		X	
Georgia	X		No	comment
Hawaii		X	No	comment
Idaho	X		X	
Illinois	X		No	comment
Indiana	X			X
Iowa		No comment	No	comment
Kansas	X		X	
Kentucky	X		No	comment
Louisiana		X		X
Maine	X		X	
Maryland	X		No	comment
Massachusetts	X		X	
Michigan	X			X
Minnesota	X		X	
Mississippi	X		No	comment
Missouri	X		No	comment
Montana		X		X
Nebraska	X			X
Nevada	X		No	comment
New Hampshire	X			X
New Jersey	X		X	
New Mexico	X		X	
New York	X		No	comment
North Carolina	X		X	
North Dakota	X		X	
Ohio		X		X
Oklahoma		No comment	No	comment
Oregon	X		X	
Pennsylvania	X		No	comment
Rhode Island	X		X	
South Carolina	X		X	
South Dakota	X*		No	comment
Tennessee	X		X	
Texas		X	X	
Utah	X		X	
Vermont	X		X	
Virginia	X		No	comment
Washington	X		X	
West Virginia	X		X	
Wisconsin		X	No	comment
Wyoming		X	No	comment
	38	9	21	8

Some 38, or 76 percent of the nation's insurance commissioners said they welcomed language to help them regulate mail order Medicare supplementary insurance, 9 commissioners (18 percent) were opposed. 3 additional commissioners had no comment.

Twenty-one (21) commissioners, or 42 percent said they favored the extension of this language to all health insurance. 8 commissioners, or 16 percent disagreed. The remaining 21 did not comment on the question.

\*On the basis of the Committee's May 21, 1979 questionnaire. The October 5 survey form had not been returned as of January 1, 1980.

## VIII. FINDINGS AND CONCLUSIONS

This section contains thirty-three (33) conclusions about cancer insurance which the House Select Committee on Aging believes are justified by the evidence. Following each major conclusion is a list of supportive evidence which is taken from other parts of this report. The list following each conclusion is merely illustrative and not an exhaustive catalogue of the evidence available on each point.

### **CONCLUSION (1): SOME COMPANIES SELL A DISPROPORTIONATE NUMBER OF CANCER INSURANCE POLICIES TO THE ELDERLY**

While the elderly constitute 11 percent of the U.S. population, they account for a disproportionate share of cancer insurance sales. As Representative Joseph Czerwinski wrote, "It is often the most unsuspecting people such as the elderly who get 'taken in' by such policies."

As RL Associates noted, only 10 percent of Union Fidelity's policyholders were under age 60. Price Waterhouse found that American Family's mean policyholder age at the application date was 56 and the mean age at the filing of a claim was 66.2 years. RL Associates found the mean age of those who purchased American Family policies at home as close to 70. RL Associates also found that "to facilitate door-to-door sales," agents were encouraged to obtain voter registration lists as a technique to identify senior citizens. American Family's suggests that only 11 percent of its sales were to persons over 65.

RL Associates also found that American Income sells cancer policies primarily to working aged people.

Bankers Life and Casualty told the Committee that they do not market cancer policies to senior citizens since the combination of Medicare and Medicare supplementary policies which most seniors have is comprehensive. Says Banker's, "There is no need for dread disease coverage when comprehensive insurance does exist."

### **CONCLUSION (2): SOME COMPANIES IMPROPERLY IMPLY AN ENDORSEMENT FOR THEIR PRODUCT FROM THE AMERICAN CANCER SOCIETY**

#### *Support*

1. The State of Massachusetts, in its reports, says that some insurers mention the name of the American Cancer Society in their advertising as often as their own name. The purpose is to imply the endorsement of the well respected Society.

2. According to Dr. William Markel, an officer of the American Cancer Society, who was quoted in the June 13, 1979 *Washington Post*, the Society does not endorse cancer insurance. He said: "They (can-

cer insurers) are using fear of cancer to build one of the fastest growing businesses in the country.”

3. *Newsweek* of December 17, 1979 says, “The American Cancer Society officially opposes cancer insurance.”

4. See further the Ohio Attorney General’s report and statement of Mary Bach, Esq., quoted in Section III of this report. Moreover, Clair A. Snyder, Chairman of the Board of the Pennsylvania Division of the Society said :

ACS statistics are often used in promotional pieces to scare people. If such scare tactics and attempts to link the policy with a reputable organization are necessary to sell a particular insurance policy, one must question why it can’t be sold on its merit alone.

### **CONCLUSION (3): MOST INSURANCE COMPANIES WHICH SELL CANCER INSURANCE USE FEAR TACTICS TO INDUCE PEOPLE TO BUY POLICIES**

Cancer insurers tacitly acknowledge that they play on people’s fears offering the excuse that all insurance is sold on fear. In response, the Massachusetts Insurance Department says :

It is clear, however, that the cultivation of fear plays so large a role in regard to no other insurance product. Automobile accidents occur more frequently than cancer, and can cause either death or painful and permanent disability; but auto insurance agents do not usually recite the grim statistics of accident carnage to sell policies. Heart disease kills more people than cancer, and costs more; but companies selling basic health insurance (which covers heart disease and nearly all other illnesses) do not ordinarily compete for business through statistical polemics alleging the prime importance of that disease.

The studies and experts quoted in the report may offer differing views on some aspects of the questions but they are unanimous in the conclusion that both cancer insurance companies and their agents heighten the public’s fear of cancer in order to sell this product. This section deals with fear tactics used by companies. Another section examines the support for the conclusion that agents use scare tactics and “skeleton rattling” in order to sell policies.

#### *Support*

1. Questionnaires to the nation’s insurance commissioners by the House Select Committee on Aging, December 1978, asked if commissioners had found that insurance companies employ fear tactics in the sale of cancer and dread disease insurance. An amazing 72 percent or 36 commissioners answered in the affirmative. Only 6 commissioners or 12 percent of the total said they did not find such abuses. The remaining 16 percent were unsure. See Section V of this report for more details.

2. The Massachusetts Insurance Department, in their report summarized in Section V, came to the firm conclusion that cancer/dread

disease merchants create a climate of fear in order to sell their policies. The Department found a good deal of "skeleton rattling" by companies in this field:

The Division of Insurance found a pattern of selling that depends essentially on evoking fears about this disease. In truth, the lowest common denominator of all cancer insurance selling is the unabashed campaign to inform all consumers why, if they are not already scared to death of cancer, they unquestionably should be.

The report mentions the use of graphics depicting, "a gnarled and menacing growth, identified as 'cancerous tissue' spreading across a scarlet background and the names of celebrities in white type on a 'funereal black background' pointing to a warning: 'The same thing that happened to them could happen to you.'"

3. In their June 1978 article, *Consumer Reports* concluded:

A number of insurance companies are using fear of cancer to build one of the fastest-growing businesses in the country. "Cancer will strike one in every four Americans, two of every three families," one company's brochure points out. "If the doctor told you that you or a member of your family had cancer . . . it would take thousands of dollars for cure . . . on what bank would you draw the check?" asks another company's brochure.

4. Raymond D'Amico of the New York Insurance Department told the Wisconsin *Capital Times* in 1976 that "the fear element had something to do with it" (the State's banning cancer and other dread disease sales). "Some companies use fear tactics to sell their insurance," he said.

5. One of the reasons why New Hampshire took action to bar cancer sales is because, "by its very nature, such a policy invites a sales pitch based on fear."

6. *Business Week* of January 15, 1979, noted that cancer kills far fewer people than heart disease but there is great fear of cancer in American society. It continues:

Cashing in on this fear is the obscure but increasingly controversial American Family Life Assurance Company of Columbus, Georgia which 15 years ago became the nation's first marketer of insurance against cancer.

7. The June 17, 1979 *Philadelphia Bulletin* began its story with the line, "It's a sales pitch fed by fear and uncertainty". The story also makes reference to an insurance company which was trying to take advantage of the Three Mile Island disaster to sell cancer insurance policies.

8. The August 28, 1979 *Wall Street Journal* quoted Robert Reich, Director of the Office of Policy Planning and Evaluation of the Federal Trade Commission as saying:

There is evidence that many companies selling cancer insurance are preying on the customer's fear of cancer through the use of scare tactics.

9. The August 28, 1979 *Wall Street Journal* says in part:

Some of the concerns offering cancer insurance have used grim sales pitches to attract customers. . . . "There are four in your family," warned a personalized letter sent by Union Fidelity Insurance Co. "Chances are that one of them will contract cancer." Another Union Fidelity brochure listed celebrities such as Babe Ruth and Jack Benny, both of whom had cancer, and stated, "This can happen to you."

The story also mentions an ad by World Life & Health Insurance Company. The ad said: "Don't be one of those people who refuses to face the frightening facts of cancer."

10. Both the June 1979 *Washington Post* and the December 1979 *Changing Times* mentioned an agent for Mutual of Omaha. Says *Changing Times*:

The fear of cancer is oversold. Shortly after the nuclear power plant accident at Three Mile Island, Pennsylvania, an agent for Mutual of Omaha was peddling cancer policies door-to-door in nearby Harrisburg (he sold 19 in all, the company says).

Adds *Changing Times*:

The sales letters pull no punches. "Cancer is so horrible and dreaded a disease that the normal reaction is to say, 'It can't happen to me . . .'" Yet the "odds are very high that someone in your family will be stricken . . . so you must protect yourself and your family from the crushing costs . . . Most people's financial resources are no match for the overwhelming costs of today's treatment."

11. Says Joseph Belth, Professor of Insurance at Indiana University:

Not only are limited forms of insurance generally purchased irrationally, but also the marketing of such insurance places heavy emphasis on fear. The sale of all insurance is to some extent based on fear, but limited forms of insurance place particular emphasis on fear. For example, cancer insurance advertisements may feature—in large letters surrounded by a black border—the statement that "What happened to Nat King Cole could happen to you!" And just as the "white knuckle" type of airplane passenger is about to board the plane, there is the trip insurance counter or vending machine ready to make the impulse sale based heavily on fear.

12. In his investigation of American Family Life Assurance Company, Attorney William Baldwin, retained by the Massachusetts Department of Insurance, concluded:

The next common theme is some form of presentation regarding the debilitating costs of cancer treatment. Fear of the cost of cancer may be the single most significant factor in influencing individuals to purchase this insurance. In evaluating the specific harm that arises from an appeal to the emotions, it must be remembered that such appeals do not lead the consumer to make a decision upon a rational basis.

13. RL Associates which conducted their own study of American Family on behalf of the Massachusetts Insurance Department, reached a similar conclusion: Fear of cancer or the cost of cancer was the primary motivation in the purchase of a policy. The policyholders chose American Family because "it was the only policy they had heard of, because it was recommended or because of the influence of the agent."

At least some of this information about incidence had come from the agent. Three-fourths of those who bought through an agent said he had mentioned that "1 out of 4 Americans will eventually get cancer," while almost as many said he had mentioned that "breast cancer strikes more women than any other form of cancer."

However, even though purchase was motivated by fear of cancer and its costs, most American Family policyholders had little knowledge of what the policy would pay should a cancer attack occur.

14. In its November 28, 1978 report, the House Committee on Aging reached the identical conclusion, with respect to American Family:

After evaluation, it was clear the basic sales presentation for the company cancer policy is designed to frighten and upset people regarding cancer and its costs—and to create a solid platform for agents to sell the cancer program. The trainee was informed that this presentation should be preceded with the phrase, "When you get cancer, (not if you get cancer) this policy will provide . . ."

Agents for the company were taught to emphasize that one in every four people will develop cancer and that two out of three families on (name the sales prospect's street) will be affected by the general disease. The point is reemphasized for those who are resistive to the sales technique in the retort: "We do know that only one family out of three in your neighborhood will not be affected by the disease."

For those who still resist saying they don't have the money, the retort designed to heighten fears is, "If you can't afford \$5 a month, you certainly can't afford cancer, can you?"

15. In their market conduct examination of American Income Life Insurance Company's cancer policies, the accounting firm Coopers and Lybrand said in part:

The marketing method is designed to create or enhance the consumer's fear of contracting cancer. The visuals include a page of names, printed on a black background, of famous individuals who have died of cancer, and a corresponding page on which the following words appear: "Cancer Can Happen To You." The associated verbal presentation recites statistics concerning the number of Americans who have or will get cancer.

The inclusion of this otherwise superfluous information creates or enhances an emotional atmosphere of concern about contracting cancer. Insurance purchases should be contemplated and made for functional reasons, and not as a result of an artificially created fear of being afflicted with a particular malady. The infusion of this information has the effect of con-

centrating the consumer's attention on the disease itself, and away from the costs and possible benefits of the policy. This may trigger purely emotional responses to the purchaser's innate fear of cancer, and may result in a decision to purchase based on irrational reasons.

Inducing the purchase of insurance for emotional rather than functional reasons appears to violate Massachusetts General Law.

16. Coopers and Lybrand had similar things to say about the brochures used by Washington National Life Insurance Company :

The Company's brochure is replete with facts and figures concerning cancer. The inclusion of this otherwise superfluous information creates an emotional atmosphere of concern about contracting the disease. Insurance purchases should be contemplated and made for functional reasons, and not as a result of an artificially created fear of being inflicted with a particular malady. The infusion of this information has the effect of concentrating the consumer's attention on the disease and may trigger purely emotional responses to the purchaser's innate fear of cancer.

The creation of a climate whereby the insurance purchase is made for emotional rather than functional reasons appears to violate Massachusetts Law.

17. Attorney Arthur McCabe was retained by the Massachusetts Insurance Department to analyze the marketing materials used by Union Fidelity to sell cancer insurance. He said the materials violate Massachusetts law :

*Violation.*—The entire thrust of the letter and the format employed has the tendency to create fear or trepidation in the mind of the consumer with regard to the probability of getting cancer and its subsequent cost. By emphasizing the estimates of the incidence of cancer and by depicting and quoting well-known, and respected public figures as being victims of cancer, an atmosphere of fear and anxiety is promoted in which the consumer may be misled about the need for and the benefits of the company's cancer benefit policy. The emphasis placed upon the emotions associated with cancer rather than the actual benefits of the plan has the tendency to mislead.

*Violation.*—The use of the pictures of famous deceased people, all of whom had cancer, accompanied by the warning that the same thing could happen to the prospective purchaser, tends to exaggerate the nature and extent of the policy benefits and loss coverage because it fails to indicate whether or not the deaths were caused by cancer which the policy would cover, implies that somehow the policy will provide protection from cancer-related death, and leads to an emotional, rather than functional, response to the need for such policy.

18. RL Associates were also retained by the Massachusetts Department to study Union Fidelity. They reached parallel conclusions :

The primary motivations cited by respondents for choosing the Union Fidelity was that it was the only cancer policy they had ever heard of or that it was made conveniently available through the mail. The underlying motivations for buying a cancer policy at all were related to fear of the disease itself or to its cost and widespread incidence among the population.

#### CONCLUSION (4): SOME COMPANIES EXAGGERATE STATISTICS TO PROMOTE CANCER INURANCE SALES

Cancer insurers exaggerate statistics in order to heighten fears about cancer and persuade their customers that they need a policy. One of the most common exaggerations is the assertion that 1 out of every 4 people will contract cancer and that cancer is on the increase. In fact, as the Massachusetts Department of Insurance points out in their report, the overall incidence of cancer has decreased slightly in the past 25 years. The often-quoted "one out of four" figure could lead to the erroneous conclusion that one-quarter of the population now has cancer, says the report. More accurately, 1 in every 280 Americans will contract cancer but even then the figure is misleading because this includes many cancers that are preventable or which are not severe, dangerous or costly.

##### *Support*

1. Price Waterhouse identified several potentially misleading statements in American Family's brochure. For example, the AFLAC brochure says:

88,000 women will develop breast cancer this year . . .  
 Source: '76 Cancer Facts and Figures—American Cancer Society. 326,000 men will develop cancer this year . . . Source:  
 '74 Cancer Facts and Figures—American Cancer Society.  
 326,000 women will die this year from breast cancer . . .  
 Source: '74 Cancer Facts and Figures—American Cancer Society.

As Price Waterhouse points out, the American Cancer Society's publication says that the figures are *estimates* and "are offered as a rough guide and should not be regarded as definitive." Obviously, they are presented as if they were definitive by AFLAC.

2. The House Select Committee on Aging made similar charges in its November 28, 1978 report, summarized in Section III of this report. In one instance, the company suggests that agents tell customers that their chances of having a fire in their home is about 1 in 25 but their chances of getting cancer is 1 in 4.

3. Coopers and Lybrand, in their examination of Washington National, found that many of the statistics that were used were not identified, were outdated and misleading, in violation of Massachusetts law.

4. Attorney Arthur McCabe found several violations of law with respect to Union Fidelity's cancer policies and their use of statistics:

- Cancer statistics are stated as fact when they are estimates.
- Even as estimates, they have a capacity to mislead because they fail to cite necessary demographic, occupa-

tional, social and environmental factors which create variations in the incident and effect of cancer.

- The statistics are not clearly identified. They are not sufficiently clear to avoid deception.

(The) omission of the underlying facts on which cancer treatment expenses are computed and analyzed tends to mislead the prospective customer as to the benefits payable and losses covered and to exaggerate the benefits beyond the terms of the policy.

## CONCLUSION (5): MANY COMPANIES SELLING CANCER INSURANCE BELABOR CANCER COSTS

### *Support*

1. The Massachusetts report notes that cancer insurers overstate the cost of cancer both to the society in general and to individuals who develop the disease. Companies assert that the average cost of treatment is between \$20,000 and \$40,000 for an individual and something like \$5 billion for the nation in general. The report says:

Like the statistical presentations used to demonstrate the high incidence of cancer, the company pronouncements on cancer costs are objectionable on several grounds. Adjectives like "crushing," "smothering," "staggering," and "astronomical" are obviously calculated to alarm without informing the consumer, and vague references to the possibility of bankruptcy for cancer victims likewise provide no quantifiable measure of the likelihood or extent of catastrophic loss.

The report notes that there are very few reliable studies for either the societal or individual cancer costs. The best information available to the Massachusetts department is that long-term cancer patients with serious cancer strains faced an average cost of \$10,000.

2. The report of the House Select Committee on Aging, summarized in Section III, carries a sales presentation from American Family Life Assurance Company. That sales presentation refers to the "Sidney Cutler report" which "pointed out that cancer was so uniquely expensive today that approximately only 40 percent of the costs of cancer were borne by the best in unlimited hospital and major medical plans." The same sales presentation refers to "the semi-private (hospital) room rate of \$451.71" a day noting that the person might be at the hospital for two or three weeks for treatment and may incur loss of income which may be permanent.

3. Attorney McCabe provides another example from his analysis of Union Fidelity's policies which he asserts is a violation of Massachusetts law:

The recitation of the gross economic cost of cancer to the American people is misleading because it fails to state clearly and completely the factors upon which the \$3 billion annual cost is based. There is no indication that the \$3 billion cost includes many factors such as wage loss and out-of-hospital expenses which are not covered by the cancer benefit policy. The use of the gross economic figures has the tendency to mislead the consumer.

## CONCLUSION (6): MANY FIRMS SELLING CANCER INSURANCE BELITTLE BASIC HEALTH INSURANCE COVERAGE

### *Support*

1. The Massachusetts report makes the point that cancer insurers belittle existing policies. They imply falsely that existing comprehensive policies will be of little use if an individual develops cancer. Basic health plans provide significant protection for most people, asserts the report.

[Cancer policies and advertisements] obscure the fact that many conventional health insurance policies will indeed pay for most or all of the costs of medical care for cancer.

If this conventional health insurance policy performs even moderately well, it will relieve the consumer's cancer policy of any necessity to deliver on its claim to be a major source of cancer compensation. If the conventional policy provides broad cancer coverage—as many do—it will relieve the cancer policy of any serious pressure to perform effectively even as a supplement.

The report notes that American Family Life Assurance has a policy of denigrating basic coverage because such policies pay doctors and hospitals directly. "In reality you do not have any insurance. You just pay high premiums," is a false, malicious, and patently absurd statement.

2. The report of the House Committee on Aging, November 28, 1978, quotes a portion of the standard sales presentation used by American Family Life Assurance Company:

I know I don't have to tell you about cancer and how widespread this disease is, but did you know that individual and group hospital plans, even with major medical, may not fully cover or even come close to covering the tremendous costs of cancer?

3. Insurance expert, Lindalee Lawrence, testified before the Massachusetts legislature on March 24, 1979, as follows:

Contrary to the statements and implications found throughout the marketing materials of cancer insurers, conventional health insurance policies held by at least three in four Americans under age 65 cover many, and sometimes all, of the costs of cancer diagnosis and treatment. Sales presentations that omit references to existing health insurance, or suggest that such policies provide insignificant coverage of cancer costs, are misleading in the extreme.

4. *Changing Times* makes a similar point in their December 1979 issue:

Cancer insurers are fond of quoting glowing testimonials. "Had it not been for this Supplemental Plan we would have lost the business, our home, and everything else we owned," says Beryle M. Tomlinson of Brush, Colo., whose husband spent ten and a half months in a hospital. But it's possible that had Tomlinson spent the same money on comprehensive health insurance, he might have received more in benefits.

## CONCLUSION (7): MANY FIRMS SELLING CANCER INSURANCE MISLEAD THE CONSUMER BY MISREPRESENTING OR EXAGGERATING THE BENEFITS OF THEIR POLICY

In their zeal to sell policies, cancer insurers and their agents commonly misrepresent policy provisions or exaggerate the benefits which will accrue to a policyholder. The classic case in point are the companies which promise to pay unlimited hospital benefits after the person has been in a hospital more than 90 days. The fact is that less than 1 percent of all cancer victims have stays over 90 days. Therefore, it is clear that few people will ever profit from what sounds at first like a generous provision. The little worth of these so-called "extended hospital benefits" is further seen in the fact that about .1 percent of all claim dollars is paid out under this policy provision. As the Massachusetts Department of Insurance says in their report, "the main use of this provision is to puff-up—at practically no cost, the attractiveness of their product to sales prospects."

### *Support*

1. American Family says that its goal is to pay for 50 percent of all costs associated with cancer. The company calculated that it is presently paying an average of 37 percent of all submitted charges. However, Price Waterhouse, in their analysis, concluded that this figure was "unreliable." Price Waterhouse said that American Family was paying an average of only 23.4 percent of the charges submitted to it by its policyholders.

2. Attorney William Baldwin said American Family's extended hospital benefits are illusory and deceptive. In his sample of American Family policyholders who had filed for benefits during an 18 month period through June 1978, "no claim resulted in payment of extended benefits." "In fact, none of the continuous confinements exceeded 90 days and only in one case did confinement (in the hospital) exceed 30 days."

3. Baldwin also said that the brochures and the schedules of surgery benefits on American Family's brochures are misleading:

The brochures used in selling cancer insurance appear to be inadequate, deceptive and misinformative. The incidence and cost of cancer, rather than the benefits or coverages, are used as the primary selling tool. The description of benefits payable fails to provide sufficient relevant information about the policy. The brochures also fail to disclose some of the limitations in the policy and the likelihood that coordination of benefits by other policies will apply.

4. Attorney Arthur McCabe found numerous violations of Massachusetts law among the brochures used by Union Fidelity. For instance, the company offers a free gift if the application is mailed by a certain date. McCabe says the free gift is merely a "come-on." It is merely part of the promotional material and it is available to all mass mailing applicants regardless of when they apply. Thus, the

deadline date and the implication that the gift is dependent upon prompt response is illusory and may tend to mislead or deceive the consumer. He adds:

The section beginning "cash paid for all forms of cancer" is not clear or complete and has the tendency to mislead. The policy itself provides strict standards for the diagnosis of cancer which standards do not include "all forms of cancer." The phrase "you collect full benefits" is misleading because it implies collection of the dollar amounts set forth in the policy without reference to the limitations and exclusions which may reduce or even eliminate the actual dollar payments. Although there are no literal requirements of deductibles or co-payment, the consumer generally ends up paying some of the costs incurred because of the numerous limitations and exclusions to which the benefits are subject.

5. James Clyne of the New York Department of Insurance told the House Committee on Aging that one of the reasons that dread disease policies were banned in New York was because, "We felt it was not a good bargain and created a bad situation for consumers by misleading them into thinking they had more coverage than they really did."

6. The Connecticut legislature banned such insurance in part because "many people were being misled into thinking they were buying broader coverage when they were buying a policy that would only pay if they contracted cancer."

7. Similarly, one of the bases for banning the insurance in New Jersey is that the policies are misleading.

8. Congressman Andrew Maguire said on June 13, 1979 at a hearing of the House Subcommittee on Health and the Environment, "These policies . . . simply do not do the job. People pay an enormous amount of money for almost no coverage that would ever be available to them, or if they got cancer, that would give them any coverage that was worth talking about."

#### **CONCLUSION (8): SOME CANCER COMPANIES FALSELY IMPLY AN ASSOCIATION WITH THE U.S. GOVERNMENT**

For example, Union Fidelity uses a gold seal on the lower left hand corner of an official looking certificate. In the words of Attorney McCabe:

The seal, bearing an eagle, stars and stripes, and the words, "Security, Service and Protection" is designated "Official Seal." The implication or appearance is that it is associated with or issued by a governmental authority. The seal is meaningless and it is not issued or approved by or under the authority of any governmental or private agency or association.

McCabe says the seal has a capacity to mislead or deceive and its use constitutes a violation of Massachusetts law.

## **CONCLUSION (9): SOME CANCER INSURERS USE PHONY TESTIMONIALS**

Attorney McCabe notes that Massachusetts regulations require that testimonials or endorsements by third parties be genuine and represent the current thinking of the author and if the person offering the testimonial has been paid or has a financial interest or benefit from the company, this must be disclosed to the consumer. McCabe cites this violation of law concerning Union Fidelity:

The use of testimonials by the insurer is misleading and deceptive in that some testimonials used are solicited by the insurer, which solicitation is not disclosed. Furthermore, in some cases, the text of the testimonial is taken out of context thereby altering the impression intended.

McCabe's findings on this issue are buttressed by Touche Ross which examined Union Fidelity and concluded:

Testimonial letters reprinted by the company were misused. Positive portions of one letter were used but negative comments about the company's claims processing procedures were omitted. Two of sixteen testimonial letters came from people who had never submitted a claim. In one case, the letter was written prior to the issuance of the policy by the company.

## **CONCLUSION (10): SOME COMPANIES SELL CANCER POLICIES FALSELY CLAIMING THEY ARE CHEAPER "GROUP" PLANS WHEN THEY ARE REALLY INDIVIDUAL POLICIES**

1. Coopers and Lybrand, in their investigation of Washington National said that the company was marketing what was purportedly a group policy when in fact it fails to meet the traditional tests for group policies. Said the auditors, "The practice of implying a group status when such is not the case appears to violate Massachusetts law."

2. Attorney Baldwin made a similar charge about certain American Family policies sold in Massachusetts.

## **CONCLUSION (11): SOME CANCER COMPANIES MAKE PHONY PROMISES THAT A PATIENT WILL BE PAID TWICE FOR THE SAME ILLNESS**

The Massachusetts Department of Insurance takes exception to the practice of some cancer insurers who appeal to greed in suggesting that a person would recover twice if they have both a basic health insurance policy and a cancer insurance policy. The report charges that American Family's characterization of its policy as a source of "double recovery of cancer costs is probably more blatantly seductive than, and as misleading as, the marketing presentations of insurers that allow a consumer to believe cancer policies are the sole significant source of benefits for cancer costs."

The presentation is seductive because duplicate insurance payments, though attractive when viewed in isolation, contribute to the waste and inefficiency that make health care and

health insurance costs a leading contributor to inflation and a pressing concern of families and government.

It is misleading because a consumer's other health insurance may have a "coordination of benefits" provision that will reduce its benefits when a covered service is paid for in whole or in part by American Family's cancer policy.

The phony double recovery claim also was called to *Newsweek's* attention. Writing in their December 17, 1979 issue, it said:

Some policies imply that they will pay even if a service is covered by other health insurance. Usually, however, health insurers don't permit 'double benefits' of this kind.

Attorney McCabe found these two violations of law by Union Fidelity:

- The pledge "all benefits paid in cash . . ." has the capacity to mislead the public to believe that the policy will, in some way, enable them to make a profit from being hospitalized.
- The designation "additional cash" has the capacity to mislead the public to believe that the policy will, in some way, enable the policy holder to make a profit from being hospitalized.

#### **CONCLUSION (12): COMPANIES SOMETIMES SELL POLICIES WHICH HAVE NOT BEEN APPROVED BY THE STATE**

Before policies can be sold by agents in a State, the company and its agents must be licensed. Moreover, the policies the company wishes to use must be filed with and approved by the Commissioner on Insurance. A notable exception to this is policies which are sold by mail which are not required to file their policies or to be licensed in order to sell policies. The gap in law has caused significant problems (see Section VII of this report).

As Price Waterhouse learned, American Family was selling several policies in Massachusetts which were not approved. In fact, approximately 7.7 percent of all policies held by Massachusetts residents had not been approved by the Massachusetts Commissioner on Insurance.

#### **CONCLUSION (13): SOME COMPANIES REDUCE BENEFITS SO THAT THE POLICY THE CONSUMER RECEIVES PROVIDES LESS COVERAGE THAN THE ONE THEY BOUGHT**

Coopers and Lybrand found evidence that some policyholders in Massachusetts that had American Income policies had such coverage "reduced prior to the policy issuance to correspond with the company's stated premium amount without the consent of the policyholder."

#### **CONCLUSION (14): SOME COMPANIES SAY THEIR POLICIES ARE GUARANTEED FOR LIFE AND THAT RATES WON'T INCREASE. HOWEVER, RATE INCREASES ARE INSTITUTED NONETHELESS**

##### *Support*

1. The House Select Committee on Aging pointed out that it was unfair for a company to tell their insured that there would be no rate

increases when future rate increases are likely. American Family agents were taught to tell the prospect that the policy is:

. . . guaranteed renewable not just to age 65, but for life and that premiums do not increase or decrease because of age, (although it does appear in small print in the CancerCare brochures). What is not mentioned is that the premiums can increase if the commissioner of insurance approves an increase for all holders of a particular policy in force in a particular state.

2. As noted in Section III of this report, American Family has instituted rate increases in several States and policyholders have complained to their local insurance commissioners and to Congress.

3. Coopers and Lybrand pointed out that policies sold by American Income are subject to this same liability:

The policy is guaranteed renewable, but the company has reserved the right to increase the premiums uniformly on all policies in force in Massachusetts. The fact that premiums may be adjusted at the company's option without specific Division approval is not conspicuously disclosed in any of the marketing materials.

The failure to conspicuously disclose the potential for premium increases without Division approval appears to violate Massachusetts General Law.

4. Similarly, Coopers and Lybrand found problems with Washington National's policies:

The policy is cancellable during the life of the insured, and the premiums may be increased. Although the material creates an impression that the policy is noncancellable as long as premiums are paid, the insurance coverage can be terminated by cancelling the contract between the Company and the sponsoring organization. The policy allows for a change in premium rates by reserving that right.

Selling a specified disease policy which is cancellable during the lifetime of the insured and for which premiums may increase appears to be a violation of Massachusetts law.

## **CONCLUSION (15): COMPANIES SELLING CANCER INSURANCE OFFER A PRODUCT WHICH HAS VERY LIMITED ECONOMIC VALUE**

### *Support*

1. The U.S. General Accounting Office was asked to evaluate the economic value of various dread disease and Medicare supplementary policies. GAO confirmed that the best index to the economic benefit of a policy was its loss ratio.

Loss ratio refers to the proportion of gross premiums which, on average, is returned to the policyholder in the form of benefits. Loss ratios are generally expressed in percentages. The higher the percentage the better the value of the policy to the insured. If a company

returns 55 percent of premiums to the insured in claims it is said to have a 55 percent loss ratio. The remaining 45 percent figure in this example is made up of profits, commissions to salesmen and administrative costs.

Blue Cross, Blue Shield and many commercial insurers have loss ratios of more than 90 percent. The national average for health insurance is 80 percent. As noted, most cancer insurers have loss ratios well below 50 percent.

While American Family says that its loss ratio over the life of a policy (30 years) is really 56 percent and not 43 percent (computed for calendar year 1976 by GAO), GAO pointed out shortcomings in their computation:

- Most people don't keep a cancer policy more than 5 years.
- The 56 percent figure includes reserves, that is, interest on policyholders money, and when this is subtracted, the real 30 year or lifetime loss ratio is more like 49 percent.
- The 56 percent calculation was made on the basis of a hypothesis and does not relate to any particular policy.

GAO also found that there were disparities between loss ratios that companies had for their health insurance business in general and for cancer insurance policies. For example, Union Fidelity had a 49 percent loss ratio overall but its ratio on cancer insurance was only 19 percent. Liberty National had a 46 percent ratio overall and a 26 percent loss ratio on cancer insurance.

Only two companies could be found that had loss ratios of 60 percent or better on cancer insurance policies: ITT Life Insurance Company and Mutual of Omaha. Many were at or below 40 percent and therefore represented unreasonable purchases.

2. Touche Ross and Company found that Union Fidelity's loss ratio for cancer policies sold in Massachusetts in 1977 was 17.6 percent. The company's two biggest policies had loss ratios of 24.6 and 3.4 percent respectively.

3. Coopers and Lybrand found that American Income's loss ratio for cancer policies sold in Massachusetts was 25.17 percent. This means that roughly 75 cents on the dollar paid for the purchase of cancer policies are retained by the company in profits, commissions and administrative expenses.

4. William T. Baldwin wrote that American Family's policy "is a high markup, low value item." Commissions ranged from over 50 percent to a low of 13 percent of first year premiums. Price Waterhouse said "the rate of incurred claims to earned premiums for Massachusetts policies for the period January 1, 1977 through June 30, 1978 was approximately 42 percent. However, American Family's two most popular policies sold in the State showed incurred loss ratios of 33.2 percent. Both Price Waterhouse and Attorney Baldwin note that the company increases rates when loss ratios go over 50 percent.

5. The 43 percent loss ratio for American Family is also confirmed by the 1978 Argus Guide, an insurance industry publication. (See *Newsweek*, December 17, 1979).

6. Speaking of a 42 percent return on premiums, former Pennsylvania Commissioner of Insurance Herbert Denenberg said: "The Pennsylvania lottery does better in returning 45 cents in benefits to the public." Denenberg also said:

Some policies—known as dread disease policies—are so narrow in coverage they pay if and only if you get a certain disease. Usually the disease covered is cancer. Sometimes the policies include other "dread diseases" such as leukemia, spinal meningitis, rabies, polio and the like. While not all limited disease policies are exactly alike, none gives you the broad coverage you want and need. When you buy these policies, you're not insuring, you're gambling.

7. Mary Bach, Esq. of the Center for Public Representation said:

Buying a cancer policy is much like buying a lottery ticket. The value of such coverage depends on the chance that one will contract the disease. If one buys cancer insurance, it would follow that heart disease insurance, arthritis insurance, etc., should also be purchased.

8. The Ohio Attorney General's office wrote about American Family:

If it appears that AFLA premiums provide little in the way of benefits, last year's cost/benefit figures filed by AFLA with the Ohio Department of Insurance confirms that appearance. For health and accident benefits AFLA paid out in Ohio only 40% of the premiums it collected in the State. This compares with 90% of premiums paid out by Blue Cross. Nor was last year in Ohio atypical for AFLA.

9. Donald B. Elliot, CLU, wrote:

Cancer and other dread disease insurance policies are designed to line the pockets of company's stockholders. The companies did not return a fair percentage of premium dollars to the policyholder in the form of benefits.

10. An Executive with Commonwealth National Life Insurance Company wrote: "My investigation revealed that these people (cancer insurers) were making an exorbitant profit on this very marketable product."

11. A Poll of State Insurance Commissioners.

Over half of the nation's insurance commissioners were willing to go on record as saying dread disease policies generally have very limited economic benefit. Fourteen commissioners, or 28 percent, disagreed while the remaining 20 percent, or 10 commissioners, said they were simply unsure.

12. A Poll of the Top 50 Health Insurance Companies by the House Select Committee on Aging produced similar results.

Asked if they would agree that dread disease policies have very limited economic value, 26 of the top 50 insurance companies, or 52 percent of the total, answered in the affirmative. Fifteen companies, or 30 percent, answered in the negative. Seven companies, or 14 percent, had no comment, and two more representing the remaining four percent did not answer the Committee's inquiry.

Asked if they would go so far as to charge that dread disease policies were "close to being a worthless product" only 8 companies, or 16 percent, responded in the affirmative, while 22 companies, or 44 percent, of the total answered in the negative. Two companies made no response, for 4 percent of the total, and 18 companies, for 36 percent, had no comment to the question.

Insurance executives were in agreement that if the question asked had been stated as follows: "Do you agree that dread disease policies that generally have loss ratios well below 50 percent have limited economic benefit?" almost all insurance company executives would have answered in the affirmative.

Among those companies with comments, Aetna Life and Casualty said, "We do not believe these policies provide sufficient economic benefit to our policyholders . . . we do not market them in any State." Among those who expressed similar sentiments were Bankers Life of Des Moines, Connecticut General, State Farm Life Insurance Company and Imperial Life Assurance Company.

13. Sam Allalouf, public relations director for Cancer Care and the National Cancer Foundation, which provide aid and guidance to people with advanced cancer and to their families likens it to buying "auto insurance policies part by part, with separate policies for the engine, radiator, transmission, and other components."

14. Dr. Howard Winklevoss of the Wharton School of Business was quoted in *Consumer Reports*, June 1978 saying, "Cancer insurance is as close to being a worthless product as you can find. It is really an embarrassment to the insurance industry."

15. In his 1972 Senate testimony, and in later writing, former Pennsylvania Insurance Commissioner Herbert Denenberg said:

A clever company can establish the ultimate in low returns—a "dread disease" policy that returns only 7 cents on the premium dollar. It would seem that the public would be too smart to fall for such a fraud, but millions of policyholders are paying premiums each year for such policies.

In December 1978 he told a reporter with the Knight Ridder chain, "The only thing that's good about cancer insurance is that it makes a lot of money for those selling it."

16. Robert Reich of the Federal Trade Commission told the *Philadelphia Bulletin*:

The coverage is not good at all. And the companies are making a large amount of money. Cancer insurance is really an embarrassment to the industry.

Reich has also been quoted as saying that cancer insurance is like a lottery ticket and not a very good gamble either.

17. The New York Insurance Department, just after banning the sale of dread disease policies, called cancer policies, "The worst abuse in commercial health insurance."

18. John Amos, President of American Family Life Assurance Company is quoted in the March 1, 1977 edition of *Forbes* as saying:

We provide a valuable service to policyholders who have a claim. For those who don't have a claim, well, I guess we'd have to confess to being a ripoff. Just the way that fire insurance is a ripoff for anyone who doesn't have a fire.

19. *Changing Times*, in their December issue in an article entitled, "Why Cancer Insurance Is a Bad Buy," said in part: "The case against cancer insurance is persuasive."

20. Earlier in this report, an authority on Las Vegas slot machines was quoted as saying that they are set to give the Casino a 5 to 30 percent share of the money paid into them. In other words, a minimum of 70 percent is returned to the customer. From an examination of loss ratios of various cancer companies as established by the General Accounting Office, it is clear that slot machines are a better gamble than dread disease insurance.

**CONCLUSION (16): MANY PEOPLE WILL NEVER RECOVER BENEFITS FROM THEIR CANCER INSURANCE POLICIES BECAUSE OF COORDINATION OF BENEFITS CLAUSES CONTAINED IN THEIR BLUE CROSS/BLUE SHIELD POLICIES<sup>1</sup>**

Cancer policies are sold as a supplement to existing insurance plans. Sometimes they play to the greed of the buyer by suggesting that he may recover double from his insurance in the event of an illness or an accident. Fortunately or unfortunately, many comprehensive insurance policies, especially those sold by Blue Cross/Blue Shield contain a clause which says that the amount that they are obligated to pay will be reduced dollar for dollar by the obligation (benefits paid) by any other insurer.

What this means is that many people will be out of luck if they plan on using money from their cancer policies to pay non-medical expenses or to replace lost income caused by their not working.

*Support*

1. William T. Baldwin wrote in his market conduct examination, summarized in Section IV of this report :

It is clear that coordination of benefits is a very real problem for American Family policyholders. The provisions of the Blue Cross/Blue Shield contract will cause coordination. Blue Cross/Blue Shield coordinates against other policies on the basis of "item(s) of service or care."

He adds that American Family's advertising materials fail to mention the coordination of benefits problem. In attempting to make a lemon into a lemonade, the company boasts that it will not coordinate benefits against any other insurance policy—it says nothing about those companies which will coordinate benefits against its policies. This failure is viewed as misrepresentation and as a violation of the Massachusetts laws and regulations.

2. RL Associates came to the same conclusion :

Since virtually everyone in the sample over 70 is covered by Medicare and three-fourths have Blue Cross/Blue Shield coverage as well, it is probable that there is a significant problem of coordination of benefits.

---

<sup>1</sup> American Family was no concerned about such clauses that they brought suit in Federal Court to have coordination of benefits clauses declared unreasonable and in violation of the Sherman Act. The District Court found that such clauses were not unreasonable, and the Circuit Court agreed. See *American Family v. Blue Cross of Fla. Inc.*, 486 F. 2d 225. American Family's appeal to the U.S. Supreme Court was declined on Apr. 2, 1974. Specifically, the Court declined to review the decision upholding the right of Blue Cross and other health insurance companies to deny benefits to claimants who recover on another policy covering the same risk.

3. The Attorney General of Ohio came to the same conclusion: "Our investigation found that American Family Life Assurance Company policies provide little additional benefits over State (Blue Cross/Blue Shield) hospitalization plans." The memo to State employees continued:

Under the coordination of benefits clause of the group Blue Cross program, for every dollar provided by another medical insurance company, group Blue Cross reduces its payment one dollar. In other words, for any of our employees who belong to group Blue Cross the additional premiums paid to AFLA buys no additional medical coverage. I might add that most of our employees do participate in Blue Cross plan.

Not surprisingly, American Family brought suit against Blue Cross/Blue Shield to try to stop them from coordinating benefits against their cancer policies. AFLAC was not successful even though they appealed the adverse decision through to the U.S. Supreme Court. But the problem relates to all cancer insurers, not just American Family.

4. Coopers and Lybrand found that Washington National cancer policies were subject to the same coordination of benefits clause and policyholders could expect to see their Blue Cross benefits reduced if they had a cancer plan from Washington National. The auditors said it was a violation of Massachusetts regulations for the company not to inform consumers of the "very real possibility" that their benefits will be reduced.

5. Coopers and Lybrand found a similar problem with cancer policies sold by American Income Life Insurance Company saying the company's marketing methods misrepresent the effect of having other insurance, by saying that their plan will pay benefits regardless of the existence of any other kind of insurance.

6. Attorney McCabe found a violation of Massachusetts law in the statement:

"Provides benefits for cancer treatment in addition to any group insurance plan or Medicare" is misleading and deceptive because if these other plans have coordination of benefits provisions, then the benefits offered by the company plan are "instead of" or "in lieu of," rather than "in addition to," these other benefits.

7. RL Associates also confirmed the existence of a severe problem for Union Fidelity cancer policyholders:

More than three-fourths of the entire sample was covered by Medicare. Given the high average age, this is not surprising, but it is significant from the standpoint of coordination of benefits. Similarly, despite their age, two-thirds of the sample were covered by Blue Cross/Blue Shield. Only about 5% of the entire sample had neither Medicare nor Blue Cross/Blue Shield coverage.

8. *Changing Times* summarized in its December 1979 edition that some cancer insurers make much of the fact that their policies will provide a windfall—double recovery if the policyholder already has comprehensive health insurance:

But it's not always possible to collect from two or more insurance policies for the same health care costs. True, a number of cancer policies promise to pay the beneficiary directly, in cash, no matter how much he may receive from other insurance. However, the other insurance often contains a coordination of benefits provision and won't duplicate benefits paid by another policy. A group plan, such as Blue Cross and Blue Shield, may not permit double recovery if the cancer insurance is also a group plan but might pay claims if the cancer insurance is an individual policy.

### **CONCLUSION (17): MONEY SPENT ON THE PURCHASE OF A CANCER INSURANCE POLICY COULD BE BETTER SPENT ON IMPROVING ONE'S COMPREHENSIVE INSURANCE COVERAGE**

One of the major premises of sellers of cancer insurance is that there is a universal need for their product. This means they must deal with conventional health insurance in some way. As noted in this report, some cancer insurers don't mention the subject of other insurance at all, thereby suggesting that cancer insurance is all that is needed to protect the would-be purchaser. Other companies mention conventional insurance only to lay out its presumed inadequacies. As noted, Blue Cross/Blue Shield as well as many commercial health insurance policies will pay all or most of the costs of medical care if cancer is incurred and the great majority of the U.S. population currently have such coverage.

For those who do want additional insurance, supplemental policies which dovetail perfectly with comprehensive insurance plans (they do not result in coordination of benefits) are available for approximately the same cost as a cancer policy and they cover medical costs as a result of any illness or accident. Not surprisingly, there was a unanimity of opinion among insurance and consumer experts that people are better off buying these plans than cancer or any other single disease policy.

#### *Support*

Further support for this conclusion is found in the following references to this report:

1. The survey of the nation's top 50 health insurance companies found in Section VI of this report. Some 35 companies (70 percent) felt that consumers were better off expanding their existing coverage, 5 companies (10 percent) answered in the negative and the remaining 10 companies (20 percent) were unsure.

2. The Survey of State Insurance Commissioners quoted in Section V of this report revealed the following results: 35 commissioners, or 70 percent, answered in the affirmative. Only 5 commissioner, or 10 percent, of the total disagreed, the remainder were unsure.

3. Additional support for this conclusion is found in the interim evaluation of cancer insurance included in the House Select Committee on Aging's November 28, 1978 report, "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal."

4. See also *Consumer Reports*, June 1978, *Business Week*, January 15, 1979, and Mary Bach, Esq., Center for Public Representation, Madison, Wisconsin whose comments are reprinted in Section III of this report.

5. See report of the Massachusetts Insurance Department, summarized in Section V of this report.

### **CONCLUSION (18): ABUSES BY AGENTS SELLING CANCER OR OTHER DREAD DISEASE INSURANCE POLICIES ARE WIDESPREAD**

In its November 28, 1978 study, the House Committee on Aging charged that there were widespread and serious abuses among agents who sell Medicare supplementary insurance. Although this report primarily deals with company abuses, the evidence is overwhelming that these same abuses occur among agents who sell cancer insurance.

As noted in the report, part of the reason for these abuses is the common policy to pay on commission. Agents typically receive 50 percent or more of the first year's premium as a commission. Generally, they receive no salary and must rely on these commissions for their income. When policies are renewed, agents usually receive only 5 to 10 percent of the second and successive years premiums. Therefore, there is a strong incentive for agents to make new sales.

Some of the most common abuses by agents selling cancer insurance are listed below with supporting evidence from this report.

#### *A. Agents Use Scare Tactics*

Another section of these conclusions documents beyond doubt that many cancer insurers use fear tactics in order to sell their product. It follows logically, that if the companies encourage heightening and playing on the fears of the public that agents employed by the companies will do so as well. In some cases it is clear that companies train their agents to prey on the fears which most people have of cancer. In other cases, agents have clearly gone beyond company policy and are acting on their own initiative in taking scare tactics to the extreme.

#### *Support*

1. See the section on cancer insurance in the House Committee on Aging's November 28, 1978 report summarized in Section III.

2. In connection with the November 28 investigation, Congressman Mario Biaggi played the role of a retiree and listened to the sales presentation of two American Family agents. Congressman Biaggi said in part:

They told me that one out of four people dies of cancer . . . and they tried to create the impression that their policy provides all the additional monies you need if you get the disease. That isn't so.

3. In their market conduct examination, RL Associates said of American Family:

American Family's agents are clearly more interested in presenting the horrors and catastrophic costs, real or imagined, of cancer than they are in describing the likely real benefits of the policies they sell.

4. In their study of American Income, on behalf of the Massachusetts Department of Insurance, RL Associates said :

American Income's agents are clearly more interested in presenting the horrors and catastrophic costs, real or imagined, of cancer than they are in describing the likely real benefits of the policies they sell.

5. In their December 17, 1979 edition, *Newsweek* carried a story, "A Premium on Fear." The story said in part :

The jovial insurance salesman who appeared at the housewife's door in Plymouth, Mass., had a grim message. Pointing toward a nearby nuclear power plant, he said, "Living so close to a reactor, you really ought to do something to protect your family." The product he was pitching: an insurance policy to cover her loved ones in case they got cancer. The woman turned the salesman away, but the implications of his pitch left her in tears.

6. The June 11, 1979, *Washington Post* said in part :

Barely seven weeks after the nuclear accident at the Three Mile Island power plant, Mutual of Omaha began an intensive sales campaign in the Harrisburg, Pa. area for what has become one of its hottest selling products: cancer insurance.

"You kind of hate to capitalize on something like that," says a Mutual sales manager in Harrisburg, who nonetheless, confirms that his agents went door-to-door warning residents there that they may risk cancer because of the radiation that leaked from the power plant.

The Mutual agents are not alone in their hard sell tactics. In Charleston, SC, residents recently opened personalized letters from a Pennsylvania insurance company telling them how many of their neighbors could expect to develop cancer.

"Mr. Smith, I don't have to remind you," a typical letter would say, "that Joan (Smith's daughter) or John (his son) may be one of these unfortunate people."

The tactics of other salesmen can be more direct. "I'm selling it door to door," acknowledges a Mutual of Omaha agent in Harrisburg near the Three Mile Island (TMI) plant. People are very nervous, very anxious about TMI. In the first week that Mutual pushed the cancer policies, the agents easily sold about 100 policies there, the agent says.

One of the most blunt sales pitches has come from Union Fidelity Life Insurance Co. of Trevoise, Pa. "If it takes you five minutes to read this brochure," says one of their ads, "approximately six new cases of cancer were diagnosed during that time."

7. Insurance commissioners from several States commented about the problem with agents selling cancer insurance. For example, Michigan said, "The most insidious problem which a regulator must confront in the dread disease market is agent practices." New Mexico specifically mentioned "high pressure salesmen" as the second most important problem they face with dread disease insurance, the first being the problem with coordination of benefits. The North Carolina Department also noted that the vast majority of their problems "stem from individual performance of agents":

We have also found that the complaints are sporadic, rising as sales teams work certain areas and elect to take virtually all steps to gain access to the homes of prospects—from representing themselves as being from the "government" to representing the American Cancer Society.

8. Finally, insurance companies themselves, such as Guardian Life Insurance Company of New York, recognize the problem:

[I]t is our impression that unduly high pressure is often used by some of the salemen who peddle these products . . .

#### *B. Agents Use a Hard-Sell Approach*

Use of the hard-sell—that is high pressure sales techniques—is but the opposite side of the scare tactics coin. One tactic used by hard-sell artists was detailed by Coopers and Lybrand in their report on American Income Life Insurance Company. Agents from that company would tell prospects that they had to make up their mind that very day because agents couldn't come back to the home. The statement, of course, was untrue and a misrepresentation, in violation of Massachusetts general law. It is true the statement was designed to push the client into buying by suggesting it was "now or never."

The Massachusetts Insurance Department also criticized training materials designed to put the potential customer on the defensive. Here is one example:

[A]lways have eye contact with your prospect . . . Always nod your head slightly when looking at the prospect . . . When closing, always move in towards the person you're selling. Never back away. The slightest backward movement can lose the sale . . . Even if it seems like he'll never answer just keep eye contact and nod your head slightly. Remember, the first person who talks, loses.

Like all hard-sell businessmen, the dominant cancer insurers wage a continuing battle for sales in which technique, rather than product quality, is often the key to success. To the extent possible, it is a battle in which the winners—and the losers—have been determined in advance.

The genius of the industry's battle plan is that sales prospects are not merely outmaneuvered and outgunned; most hardly notice that the battle was done.

The burden of the plan is that, in the heat of the battle, the thin line between enthusiasm and deception is often breached.

Says *Forbes* magazine:

American Family is a hard-sell merchandising company that just happens to sell insurance . . . Amos also convened an aggressive sales force so well paid and rewarded that the company will never be licensed in New York or New Jersey which have strict limitations on agent commissions and sales contest prizes and specific bans on dread disease products.

### *C. Agents Belittle Basic Insurance Coverage*

In order to bring about a sale, agents selling cancer insurance invariably have to deal with the fact that the potential customer has other insurance. It is common for them to falsely imply that comprehensive policies will be of little use if a person develops cancer. Basic health insurance plans will provide significant protection for most people.

The Massachusetts report notes that American Family has a policy of denigrating basic coverage because such policies pay doctors and hospitals directly, saying, "In reality you do not have any insurance. You just pay premiums." This characterization is false, malicious, and patently absurd says the department.

*Changing Times* of December 1979 makes a similar point:

Cancer insurers are fond of quoting glowing testimonials. "Had it not been for this Supplemental Plan we would have lost the business, our home and everything else we owned," says Beryle M. Tomlinson of Brush, Colo., whose husband spent ten and a half months in a hospital. But it's possible that had Tomlinson spent the same money on comprehensive health insurance, he might have received more in benefits.

### *D. Agents Belabor Cancer Costs*

The first line of attack in selling a cancer policy is to generate a real fear of the disease. The second is to offer statistics about the tremendous costs of the disease and the third is to belittle existing coverage.

As noted elsewhere in this report, companies print material for the use of their agent which indicates the average cost of cancer treatment may be as much as \$40,000 over a lifetime. Quite often agents use isolated examples of individuals who have spent double this amount or more to make their point.

As noted in market conduct examinations of four major sellers done by the Massachusetts Department of Insurance, agents frequently exaggerate these costs even beyond what is printed in company brochures.

While there are few available studies, the best estimates disclose the average cost of cancer treatment is about \$10,000. This is a large amount over a lifetime but it must be remembered that conventional health insurance will pay most of these costs. . . . Further, there is little to be gained in buying a cancer policy since many major plans will coordinate their benefits against cancer insurance plans. Therefore Blue Cross or other insurers will reduce their coverage dollar for dollar for any duplication in coverage that exists if a claimant has other insurance.

*E. Agents Who Say "Make The Check Out to Me" Sometimes Illegally Take A Cut of the Action*

In its examination of American Family, Price Waterhouse was critical of a procedure which allows the agent to collect initial premiums from the insured and then remit funds with applications by agent's personal or agency checks:

This procedure could result in an agent never remitting premiums (and related applications) to the Company's home office or kiting of premiums (which occurred in the instance of one state manager as documented in the Company's September 19, 1978 minutes of the Board of Directors).

The *Capital Times* of Madison, Wisconsin noted that American Family salespersons have on occasion, "been suspended by the company for not passing along premium payments to the home office."

*F. Agents Sometimes Indulge in "Clean Sheeting"*

Clean sheeting is the failure to report a material and preexisting health condition to the company which leads to the policyholder being disqualified for benefits when a claim is filed.

The *Capital Times* noted this was a problem with American Family in Wisconsin and a man in Iowa had this complaint about another company. He said that his mother had been misled by an agent selling cancer insurance for Mutual Protective Insurance Company:

At the time of purchase in July 1978 the insured had informed the agent that she had had a malignant mole removed. The agent "specifically stated that it did not affect her eligibility." On March 13, 1979 the company denied claims submitted by the woman on the grounds of previously diagnosed cancer. "I submit the policy was sold by false assurances and suggest you reconsider your decision to pay benefits contracted for," he wrote to the company.

*G. Unlicensed Individuals Sell Policies*

There are occasional references throughout this report to the fact that unlicensed individuals have been allowed to sell cancer insurance. The *Capital Times* documents this problem with American Family in Wisconsin and Massachusetts similarly found this problem existed on a small scale in that State.

**CONCLUSION (19): COMPANIES SELLING CANCER INSURANCE EXERCISE LITTLE CONTROL OVER AGENTS; AGENTS LICENSING AND TRAINING ARE INADEQUATE**

*Support*

1. In his analysis on behalf of the State of Massachusetts, Attorney William Baldwin said the following with respect to American Family's training program:

The Company's sales training program is unacceptable because of the violation of Consumer Protection Regulations . . .

The Company does not regulate sales practices. Agents have created sales materials and practices on their own, without company supervision, although the Company was aware that the agents were doing so. Some of the materials used by agents to represent claim payments made in the past and to explain away the coordination of benefits problem constitute misstatements of the policy benefits and drawbacks.

Baldwin summarizes his finding :

The Company's sales training program appears to be deceptive and utilizes high pressure, low information techniques. Training conducted for purposes of the State licensing examination appears to be woefully inadequate. All training for the licensing exam and most of the sales training is conducted by commissioned salesmen in the field. No records of attendance or performance are kept by them. The sales technique taught is subject to many of the same shortcomings as the policy sales brochures. It overemphasizes the incidence and cost of cancer, while not providing sufficient relevant information regarding benefits.

Past practices of the Agent's Licensing Department appear to have been inadequate. Recently instituted procedures of that department show an improvement in the manner in which applications are examined, and qualifications and references are checked out. These newly instituted procedures should be followed and applied to all phases of record keeping and follow-up in that department.

2. In their analysis of American Family, Price Waterhouse said in part:

- The Company and the State manager have no character investigation reports on file for thirty-three of the fifty-nine active Massachusetts agents as of June 30, 1978 and personal history information could not be located, for four of the active agents.
- Six Massachusetts policies were written by three unlicensed (at the time of policy issue) agents in 1977; the Company instituted new procedures in 1979 to prevent this problem from recurring.

Price Waterhouse also revealed that the Company spent a miniscule portion of its \$203 million revenues on training of personnel. American Family Assurance records disclose that during 1977 the company spent only \$245,000 nationwide for training agents, \$1000 of which was spent in Massachusetts.

3. The Madison, Wisconsin *Capital Times* found numerous complaints with respect to American Family agents, indicative of lack of control over their agents.

4. Similar charges were made by the House Select Committee on Aging against the company's operations in the State of Maryland. See summary of the Committee's November 1978 report in Section III of this report.

5. Coopers and Lybrand also criticized the Washington National Insurance Company for lack of oversight of "its prescribed procedures and practices" particularly the need to make sure that the reasons for terminations of their agents were made clear in the files.

6. Touche Ross found that Union Fidelity contracts with general agents to sell its policies and that the general agents in turn contract with subagents. Touche Ross found that the company exercises little control over its agents. It does not conduct training courses for agents and does not prepare any educational materials for the purpose of training agents. They found that 20 percent of the Union Fidelity agents in their sample had no previous work experience. Touche Ross adds in their report:

There were twenty-nine (29) agents terminated during the examination period. Seventeen (17) of the twenty-nine (29) were terminations resulting from Massachusetts Division of Insurance investigations. The annualized agent turnover during the examinations period was approximately 83%.

7. In its February 1980 market conduct analysis of American Family Life Assurance Company, the Illinois Department of Insurance found significant problems with the use of unlicensed agents. Says the report:

One hundred and forty-three sales representatives were found who solicited a total of 4,099 applications which appeared to violate the Illinois Insurance Code and/or the Rules and Regulations of the Illinois Insurance Department.

## **CONCLUSION (20): CANCER POLICIES FREQUENTLY INCLUDE UNCOMMON RESTRICTIONS AND LIMITATIONS**

### *Support*

1. The Massachusetts Department of Insurance, in its comprehensive report on cancer insurance, charges that cancer insurers resort to the use of numerous restrictions and limitations which are uncommonly harsh in the industry. The report offers the example of policies that have waiting periods during which the insurance company is not obligated to pay claims. These waiting periods are commonly 60 to 90 days—sometimes more. In general terms, coverage is excluded for disease or problems arising during the 60 or 90 day period but begins thereafter. In the cancer insurance practice, if the disease is diagnosed during the term of the waiting period, the company is excused from coverage not only for the term of the waiting period but permanently.

The small print in most cancer policies limits coverage to "definitive cancer costs." This phrase means there will be no coverage for cancer diagnosis or for health problems caused or complicated by cancer and cancer treatment or for therapy and rehabilitation.

Another classic example involves the use of a confusing, 167-word sentence by one cancer insurer to describe benefits and exclusions under its policy. The report says:

[T]he dramatic accents in which they often present their version of policy benefits, cancer insurers also know how to be subtle, indirect and occasionally inscrutable in their discussion of policy limitations. Usually collapsed into a single paragraph away from the glare of large-type headlines, color ink and graphic displays lavished on policy benefits and can-

cer statistics, the list of limitations receives much less emphasis and explanation than it deserves.

Uncommonly restrictive “waiting periods,” the restriction of benefits to “definitive cancer treatment,” and the fundamental design of cancer insurance as supplemental—and fragmentary—coverage are among the important limitations of cancer policies that are systematically minimized or ignored in many marketing materials and sales presentations.

2. Lindalee Lawrence testified before the Massachusetts legislature :

Scattered throughout (cancer insurance policies) under a diversity of headings, are a variety of other limitations that restrict payment to cancer victims. These include the “waiting period” for eligibility to receive cancer insurance protection and the numerous less-than-obvious ramifications of the restriction of benefits to definitive cancer treatment, already discussed in connection with sales presentations.

3. *Changing Times* of December 1979 also noted the uncommon waiting periods or exclusions :

Many, if not most, cancer policies pay only for “definitive cancer treatment.” This means that nothing is paid for ailments caused or complicated by cancer or cancer treatment, for rehabilitation or post-treatment checkups, or for diagnosis and pathology reports. Some companies do not mention this in their marketing materials. Others do not explain what definitive cancer treatment is.

*Changing Times* continues :

Often, radiation and chemotherapy treatments, if covered at all, are paid for only if administered during a hospital stay, even though such treatments are usually given on an out-patient basis.

With many cancer policies malignancies discovered during the waiting periods—which generally run from 60 to 120 days—are excluded altogether or are not covered for up to two years. Most regular health insurance policies do not become fully effective immediately after purchase, but if certain illnesses occur before they take effect, benefits will be paid after the waiting period ends.

Here are some of the other practices that authorities regard as deceptive :

- Playing up “extended benefits” for hospital confinements of over 90 days without mentioning that such confinements are extremely rare (the average stay for cancer patients is 14 days).
- Implying that a person can collect from two or more policies, even though this is not always true.
- Failing to disclose policy limitations and exceptions.
- Exaggerating the incidence of cancer and the cost of treatment.
- Accentuating benefit maximums that are unlikely to be paid to anyone.

## CONCLUSION (21): CANCER POLICIES COVER ONLY CANCER; WITH THE EXCEPTION OF AMERICAN FAMILY, MOST COMPANIES IMPLY COVERAGE FOR MUCH MORE

### *Support*

1. The Massachusetts report notes that from their advertising, cancer insurers convey the impression that they will pay for a wide spectrum of health related expenses. This is not true, says the report:

Against the backdrop of sweeping selling claims, the Division has traced product limitations that do not fulfill even the most modest expectations a consumer might apply to any insurance policy. Against the narrower, specific claim of cancer coverage to be a valuable insurance supplement, narrower and more specific defects have been revealed.

2. Coopers and Lybrand found a violation of State law with respect to a Washington National Policy. Said the auditors:

The company fails to specifically inform the prospective purchaser that the policy covers cancer only. Although the material states that the policy is a cancer expense policy, there is no indication, other than in the confusingly drafted exemption provision, that the policy coverage is limited to costs incurred as a result of cancer.

3. Of the four insurers examined, only American Family clearly labeled its plan as supplemental in nature. However, Lindalee Lawrence of the Massachusetts Insurance Department testified as follows:

American Family does label its cancer coverage as "supplemental" insurance in most of its policy brochures. Instead of explaining this term and focusing further light on the central question of how its policy might usefully coordinate with basic coverage, however, the company's agent presentation nimbly undercuts the "supplemental" label in its policy brochures.

If a consumer resists a sale by saying he already has a good health insurance plan, American Family agents are taught to say in rebuttal the following statement, using the statistics on cancer incidence and cost as "additional ammunition":

"I can appreciate you feeling that way, Mr. Jones, and most people fell (sic) the same; however, in reality we don't have ANY insurance. The doctor that treats you has insurance his bills will be paid. The hospital has insurance its bills will be paid. But, in reality, you *do not* have any insurance. You just pay the high premiums. Have you ever received any money from a hospitalization policy to put in your pocket? Mr. Jones, this is *YOUR* insurance. Should cancer strike any member of your family, we will pay our money directly to YOU and NOT to the doctors and hospitals."

**CONCLUSION (22): ALTHOUGH MOST CANCER COSTS ARE INCURRED OUTSIDE THE HOSPITAL, CANCER POLICIES, UNFORTUNATELY, ARE GEARED TO PAY FOR CANCER COSTS ONLY WHEN THE INDIVIDUAL IS IN THE HOSPITAL**

*Support*

1. *Changing Times* of December 1979 made this point in their article, "Why Cancer Insurance is a Bad Buy."

2. The Ohio Attorney General's Office said in their memorandum to state employees:

The cancer insurance coverage sold by AFLA covers only one disease, cancer. The policy provides for certain benefits to the insured only during a time he or she is hospitalized with cancer. This is an important limitation on coverage because much cancer treatment is on an out-patient basis.

The Attorney General continues:

The National Cancer Foundation, a social service agency in New York City which provides professional counseling and care at home for advanced cancer patients and their families, has criticized any disease by disease approach to health insurance. It found that most cancer policies provide no coverage for care at home where substantial costs, such as house-keeping, nursing and medicine are incurred. The Foundation has also observed that some policies are carefully worded to minimize hospital and physician benefits. This is true of the AFLA policy. For example, AFLA provides payments for hospital chemotherapy but not for out-patient chemotherapy. Additionally, there is even a dollar limitation on the hospital treatment.

3. The House Committee on Aging said in its November 28, 1978 report:

Although one is led to believe that cancer is designed to cover the nonmedical costs of cancer, all benefits in the cancer program are keyed to the medical aspects of cancer—which the company admits is already covered by the prospects major medical plan:

"The reason wasn't because major medical didn't do its job, it did! But they discovered that many if not most of the costs of cancer today may be non-medical—in other words, many of the costs of cancer have nothing to do with hospitalization at all."

4. Attorney Arthur McCabe found that Union Fidelity had violated provisions of Massachusetts law because of its pledge "pays cash in and out of the hospital." He said the statement had "a capacity to mislead because most benefits are contingent upon hospital confinement."

5. The Massachusetts Department of Insurance said in their report:

The typical cancer policy covers very few of the outpatient costs of cancer patients, even though for some patients these

costs may be greater than the cost of inpatient care—and even though these costs are the least well covered by some conventional health insurance policies. None of the six cancer insurance policies examined by the Division covers drugs outside the hospital, home nursing, physical therapy, special equipment, prosthetics, or nursing home care.

**CONCLUSION (23): ALTHOUGH CANCER, BY ITS VERY NATURE, BRINGS ON RELATED MEDICAL PROBLEMS, MANY CANCER POLICIES DO NOT PAY FOR THE COSTS OF THESE COMPLICATIONS**

One of the results of the requirement of pathological diagnosis of cancer before payment is that no payment can legally be made for complications or conditions which result from having cancer. One example is the person who suffers a broken hip because radiation, a kind of cancer treatment, has weakened the bones leaving them brittle. The policyholder may be very disappointed to learn that medical expenses as a result of the broken hip are not compensable by cancer insurance policies.

Mr. John Sansone, the principal examiner for the Connecticut Insurance Department commented that if while you are in the hospital receiving treatment for cancer, and cancer complicates other parts of the body, the company may refuse to pay benefits arguing that such payments cannot be paid for conditions other than cancer. Mr. Sansone added, "by its very nature, cancer complicates many parts of the body." A cancer-only policy can be compromised in many other interesting ways, according to Mr. Sansone.

Also excluded are the costs of rehabilitation from the effects of cancer and the costs of post treatment and other follow-up to make sure there has been no recurrence of the disease.

**CONCLUSION (24): SOME CANCER POLICIES WILL PAY ONLY FOR A CERTAIN TIME LIMIT AFTER CANCER IS DIAGNOSED: A FACT WHICH IS NOT ALWAYS MADE KNOWN TO THE POLICYHOLDER**

*Support*

1. Attorney McCabe found that Union Fidelity may have violated Massachusetts law by virtue of its "guaranteed renewable for life regardless of physical condition" provision. He said the provision was deceptive and misleading because "the policy will terminate three years from the date any form of cancer is diagnosed, regardless of the course of treatment of the cancer or form. Even though the cancer recedes, the customer will not have a right to renew the policy."

2. A second line of evidence consists of letters such as the following from an Illinois man :

My mother is a 72-year old terminal cancer patient. For many years, she carried cancer insurance with an ITT unit located in Thorp, Wisconsin.

The insurance company paid benefits when she underwent a mastectomy some four years ago and then paid benefits again when a related tumor was removed a couple of years later.

Some eleven months ago, she suffered a pathological fracture of the femur caused by metastatic cancer as per the pathological report and correspondence to the insurance company from the attending physician-surgeon. The insurance company refused to pay any benefits even though benefits for such an occurrence are spelled out in the policy.

The elderly patient with a continuing cancer problem, and that is what cancer is—a continuing problem, certainly does not benefit from cancer insurance.

3. The Massachusetts Department of Insurance adds these comments in its report :

Three of the six cancer policies reviewed by the Division of Insurance will pay benefits only within a specified time limit—usually three years—after the date of cancer diagnosis. Although three years may seem an adequate time in which to treat cancer, a number of cancers involve treatment of longer duration. This may be inferred from median survival times, which represent the length of time after cancer diagnosis when half the patients have died and half are still alive.

For breast cancer, for example, the median survival time is six years and seven months. Of the 50% of the patients who die within this time, a sizeable number undoubtedly die after three years from the date of diagnosis, and if they had cancer insurance, they would not have had their treatment before death covered. The 50% of patients who live longer than the median survival time would face an even longer period of potential costs without continuing protection of cancer insurance benefits.

**CONCLUSION (25): IN ORDER TO LIMIT THEIR LIABILITY, MOST CANCER INSURERS WON'T PAY UNTIL CANCER IS DIAGNOSED BY A PATHOLOGIST, WHICH CAN BE A COSTLY OR LIFE THREATENING PROCEDURE**

The House Select Committee on Aging said in its November 1978 report that one serious drawback of cancer insurance policies is that before the company will pay it must have pathological proof of the disease. The word of the diagnosing physician is not enough. Positive physical evidence is required. Often it is impossible to provide such proof. The surgery to get the cancerous tissue sample may even have the effect of spreading the cancer or result in the patient's death.

A letter from a physician quoted in Section IV of this report adds perspective to this problem :

We therefore felt he (the patient) has clinical evidence of lung cancer with a brain metastases . . . if he succumbs, we

will get (a pathological report) in autopsy and if his condition goes on to further deterioration we then can perhaps operate and get a tissue diagnosis to prove it, but I would consider this unnecessary surgery.

As the Massachusetts Insurance Department report states:

For a variety of reasons having to do with the age and health of the patient and the type of cancer involved, a pathological diagnosis is not always medically necessary, desirable, or possible. Lung cancer and brain cancer are two types of the disease in which cytological washings, CAT scanning and other diagnostic procedures are often used as a substitute for the surgical removal of a tissue sample.

For further comments, see the *Washington Post*, June 11, 1979 article by Ted Gupp and the statement by Washington D.C. Attorney Marc Botzin before the Health Subcommittee on June 13, 1979, both carried in part III of this report.

## **CONCLUSION (26): IN CANCER POLICIES WHAT THE BIG PRINT GIVES YOU, THE LITTLE PRINT TAKES AWAY**

### *Support*

1. The report of the Massachusetts Insurance Department is most explicit on this point:

[T]he real genius of cancer policies—their ability to suggest broad coverage while providing at every turn for the narrowing of benefit payments—is a constitutional trait that runs much deeper than policy language . . .

On closer examination, it may be more clearly discerned that every cancer insurance benefit provision is simultaneously an act of giving and an act of taking away. Useful for suggesting broad and varied coverage, the cancer policy's separate listing of numerous specific benefits also creates the opportunity to impose separate benefits "limits" that are specific and severe.

The typical policy pays for private duty nursing in the hospital, for example, but only to a limit of \$24 per day with a lifetime limit of \$600. The typical policy covers radiation therapy in or out of the hospital, but only "up to" a lifetime limit of \$1,000. The policy pays for hospital room and board, but only to a limit of \$60 per day for the first seven days and \$30 per day for the next 83 days.

2. The report of the House Select Committee on Aging, dated November 28, 1978 and summarized in Section III of this report, takes a standard American Family cancer insurance policy and sets forth the "big print" of what is mentioned and then spells out what is not mentioned with respect to each proposed area of coverage. There is no reason to reproduce this commentary again here. One example should suffice to provide the tone of the criticism.

Under the standard policy, the prospect is told that in addition to surgery the company will "pay for your personal physician." They will pay \$10 a day for 90 one day visits. A limit of \$900 is placed on this benefit:

**WHAT IS NOT MENTIONED** is that the average physician in the Washington, D.C. Metropolitan area will charge a cancer patient anywhere from \$40 to \$170 for one in-hospital visit! At best, under the cancer policy the holder can expect to receive no more than one-fourth of their physician's bill to be paid by the company. Remember, this benefit is only provided for in-hospital physician visits.

3. Lindalee Lawrence told her State legislature:

At first glance, the long list of numerous benefits is conducive to a feeling of well-being and security. The benefits are all different, and perhaps too complicated to remember either as individual items or in the pattern of coverage they form, but there is certainly the appearance of protection that is extensive and carefully planned.

4. Attorney McCabe said that Union Fidelity's \$150,000 cancer plan created a false impression with its "big print" which was likely to deceive. The policy emphasizes that this amount is available and yet it is "virtually impossible for the consumer to collect benefits to or approaching the policy limit." He says the company is or should be aware of this impossibility:

First, the company's own loss ratio and claims payment history is indicative of this conclusion. Second, the benefits and risks covered under the policy are inconsistent with actual medical experience in the treatment of the various forms of cancer. In order to collect the available benefits in full, the consumer would have to have cancer diagnosed more than 120 days after policy issuance and, in the 36-month period immediately after diagnosis, be confined to a qualified hospital for a minimum period of 555 consecutive days. Because the policy pays only actual costs, if the daily hospital charges are less than \$138, it is literally impossible to collect the maximum.

5. Touche Ross also completed a similar analysis of Union Fidelity's \$200,000 plan. "Since coverage does not extend beyond three years," said the report, "an insured hospitalized continuously for three years could collect \$173,910 using the company's advertized average room and board rate of \$158 per day." The practical effect of this analysis is to say that no one will ever collect the full \$200,000 and that the promise of this amount is illusory.

6. Attorney McCabe has three more violations of Massachusetts law which are even more to the point:

- The recitation of Hospital Confinement Benefits set forth within the section entitled, "Cancer Benefits Summary," has the capacity to mislead because the reduction of benefits after the first seven days is set forth in smaller print

than that used to indicate the increased benefits for the first seven days. The statement is not sufficiently clear and complete to avoid deception because it fails to include both the restrictive definition of hospital confinement, found in the underlying policy, and the restrictions on the type of institution covered, found in the exceptions and limitations portions of the policy and the advertisement. It also fails to include any reference thereto.

- The recitation of the surgical benefits is unclear and has the tendency to mislead. The benefits cite \$45 to \$750 per operation, yet the actual benefits set forth in the policy surgical schedule are substantially less than the \$750 promised. Of the forty surgical procedures listed in the surgical schedule, only four pay the the full amount. The average is less than \$450 per surgical procedure; thus, the method of stating benefits is misleading.
- The recitation of the anesthesia benefits is deceptive and incomplete because it fails to state that the anesthesia will not be covered if the anesthesiologist is employed by the hospital.

7. In their analysis of Washington National, Coopers and Lybrand found a new wrinkle: the use of a more restrictive exclusion in the policy than the one disclosed in the marketing material. The auditors said this was a violation of Massachusetts law.

### **CONCLUSION (27): CANCER INSURANCE POLICIES OFTEN EMPLOY OBTUSE LEGAL JARGON OR OTHER LANGUAGE WHICH CONFUSES THE CONSUMER**

This point is too obvious to need much documentation. Three examples should be sufficient to make the point.

1. Congressman Claude Pepper testified before the Health Subcommittee of the House Interstate and Foreign Commerce Committee:

Take these cancer policies, I can't believe that the Department of HEW would approve these cancer policies that we have had presented to our committee. We intend, of course, that cancer policies be included in our bill.

Why, at our hearing, somebody got a big laugh in the hearing room when they read one of these 100-word sentences. A Philadelphia lawyer could hardly tell what it meant.

So, the HEW would say right away, "That is deceptive; it is not a meritorious policy. We don't approve that."

2. Coopers and Lybrand criticized Washington National's policy because of the use of unclear language because it has a capacity to mislead or deceive. They said:

While the material contains numerous examples of unclear or incomplete assertions, the most critical concerns the disclosure of the policy's exemption provision. This provision is written in such a way that repeated readings are required to understand it.

3. The Massachusetts report concludes that cancer insurers are masters in the use of "obtuse legal jargon" and "circumlocution." Examples of purposely confusing, obfuscating language are offered in the report and labeled, "explicitly deceptive." Says the report:

In practice, however, cancer insurance policies are effectively designed to do through over-complication what the selling presentations do through over-simplification: simultaneously to exaggerate and obfuscate the real performance of cancer coverage.

It is the uncommon restrictiveness of some of these limitations—and above all, the unexpected placement of so many holes, ditches, and fences in a terrain where the billboards soothingly proclaim "Peace of Mind," the "\$20,000 Plan," and unlimited extended benefits—that makes them so unfair.

### **CONCLUSION (28): MANY CANCER INSURERS PROMISE MOUNTAINS OF BENEFITS BUT DELIVER MOLEHILLS OF PROTECTION**

#### *Support*

1. The Ohio Attorney General concluded: "We found that the claims made by American Family Life Assurance Company in selling their policies were exaggerated and that more comprehensive coverage could be purchased for the same or lower cost."

2. The Massachusetts Department of Insurance found that cancer policies "promised a mountain range of benefits but provided molehills of actual compensation." Says the report:

[N]o insurance policy functions more truly like a sieve than cancer coverage. Subtly, unobtrusively, but systematically and effectively, the myriad limitations of cancer insurance riddle the policy with holes that drop out about 70 percent of cancer costs, leaving them to be paid by the cancer victim—or his conventional health insurance plan.

Despite its expansive promises of "peace of mind" for cancer victims, American Family paid total benefits averaging only \$1,278 per successful claimant during the 18-month period between January 1, 1977 and June 30, 1978.

Despite policies called "the \$200,000 Plan" and "the \$150,000 Plan," Union Fidelity paid benefits averaging only \$1,406 per claimant during a similar period.

Despite stern warnings of "staggering . . . astronomical" cancer costs running to "between \$30–\$40,000 per cancer victim," American Income's average claim payment totaled only \$1,397 during a comparable time.

Creative in exploiting the fears and winning the confidence of consumers regarding a way to fill the need for cancer compensation, cancer insurers are, however, more resourceful in finding the means to reject or reduce cancer claims than in finding the willingness or the ability to pay them.

3. *Forbes* concluded that American Family's rates were too high and they were returning too little of the premium dollar back to their

insured. *Forbes* notes that the average claim runs "just \$1,600 and some 25 percent of the claims are for skin cancer, a relatively inexpensive disease."

4. Mary Bach of the Center for Public Representation said:

Cancer insurance covers only a small portion of cancer-related medical bills. A typical policy, issued by the company referred to in your article covers only \$50 per day for the first seven days of hospital confinement and \$30 for each day thereafter. The same policy pays according to a stringent schedule of benefits for surgery, attending physicians' fees, drugs, etc. The maximum payment for X-ray, radium and cobalt therapy, for instance, is \$1,000 per *lifetime* of the insured. In order to gain any coverage, malignancy is required, so that in the case of a benign tumor, coverage for surgery and other medical expenses is denied.

5. In its July 1978 report, the Federal Trade Commission said that both indemnity and dread disease policies "often produce few benefits in relation to the amounts of money invested: they typically have very low loss ratios."

6. *Consumer Reports* in June 1978 decried sensationalistic ads which it says are designed to kindle a fear of cancer and its costs but do not say much about the proposed solution:

That cancer is costly is as true as that a hurricane is windy; average medical costs associated with treatment of cancer other than skin cancer come to about \$20,000. The question is whether cancer policies offer more protection against these costs than an umbrella does against the winds of a hurricane.

*Consumer Reports* tried to find out what each of the policies would pay in a typical case:

A hospital stay of 40 days would be more catastrophic, financially, costing perhaps \$8,000. Yet only two of the companies—Mutual of Omaha and Union Fidelity—would cover more than one-third of the cost. Here are the five policies, a typical annual premium, and how they'd pay out on a hospital bill of \$8,000:

Company and policy	Annual premium <sup>1</sup>	Payouts
Mutual of Omaha, form 50 CL/CLP, series 8883.....	\$30	\$5, 150
Union Fidelity Life Insurance Co., form 1-2140.....	75	3, 480
American Family Corp., form A-6925.....	50	1, 840
Colonial Life & Accident Insurance Co., form 0610.....	27	1, 840
Lone Star Life Insurance, Co., form SPC GR 100-CAL (73).....	44	1, 560

<sup>1</sup> Premium given is for a 35-yr old single woman buying an individual plan. Group rates are generally somewhat lower, family-plan rates are generally somewhat higher.

7. In its November 28, 1978 report, the House Select Committee on Aging also examined a case study. The Committee learned that a woman with \$4,000 in medical and nonmedical costs over two years because of cervical carcinoma, would have paid \$100 premiums for American Family's popular policy and would have received \$160 in benefits. Says the report: "The company may suggest that the policy-

holder at least got her money back and then some but the fact is **only** one out of 280 who actually contract cancer will break even or **do better.**"

8. As noted elsewhere in the report, American Family aspires to cover 50 percent of the average costs of cancer but boasts that it covered about 37 percent of the total. The Price Waterhouse team found that American Family's boasts were generally unsubstantiated by fact. American Family actually paid only 23.4 percent of submitted cancer costs. As the Massachusetts Department of Insurance pointed out, this percentage further erodes over time because of the impact of inflation on American Family's fixed benefit limits.

9. Coopers and Lybrand found that American Income's marketing methods were misleading because their policies are marketed on the basis of an aggregate benefit that is unlikely to be paid. The policyholder is led to believe that he will be able to collect up to \$32,000 when there is "substantial improbability" that the person will ever be able to collect this amount. Says the report :

The marketing method emphasizing an aggregate benefit which is unlikely to be paid by the company has the capacity of deceiving consumers concerning the potential benefits of obtaining this policy, and therefore, appears to violate Massachusetts General Law.

10. Attorney Arthur McCabe leveled a similar charge at the Union Fidelity Life Insurance Company :

A portion of the letter stated ' . . . we're offering you the opportunity to be protected by the UFL \$150,000 Cancer Benefit Plan. The plan will pay you cash for cancer treatment both in and out of the hospital. And every penny of the money is paid DIRECT TO YOU . . .' This statement has the tendency to mislead and deceive. First, it is highly unlikely that the consumer will in fact collect every penny of benefits . . . Second, few, if any, of the available benefits cover treatment out of the hospital, yet the statement creates the impression of full coverage in or out of the hospital.

11. Said former Pennsylvania Insurance Commissioner, Herbert Denenberg :

The dread disease policy is perhaps the classic example. These policies may cover only medical expenses for polio, cancer, heart transplant or other combinations of dread diseases. They can be marketed at what seems to be a low premium because it is geared to return only a small percentage of premiums in benefits.

## **CONCLUSION (29): EVEN THE PROFFERED PEACE OF MIND THAT CANCER INSURERS SAY THEY OFFER IS ILLUSORY**

Cancer insurers are fond of stating that they offer the buyer peace of mind. Some companies "ingeniously quantify the abstract essence of peace of mind and imply a virtually inexhaustible source of financial protection against cancer," says the Massachusetts report.

The report says that companies use misleading figures (i.e. \$200,000 in coverage) "to puff-up—at practically no cost—the attractiveness of their product to sales prospects . . ."

[I]t is likely that most consumers receive an exaggerated, highly unrealistic impression of the practical performance of cancer insurance. And a very illusory foundation for Peace of Mind.

The Teachers Insurance and Annuity Association of America said the policies give "a false sense of security" to purchasers.

Thomas Harnett, senior Vice President and Counsel for Travelers Insurance Company of Hartford, Connecticut told the *Wall Street Journal*, "Buying a cancer policy alone instead of comprehensive coverage is like insuring a ship against fire but not against sinking." Allan Fergusson, Vice President of Prudential told *Business Week*, "It's like insuring only part of your house against fire."

### CONCLUSION (30): MANY COMPANIES SELLING CANCER INSURANCE HAVE HIGH RATES OF DENIAL OR ERRORS IN THEIR PAYMENT OF CLAIMS

The House Select Committee on Aging and probably all Congressional offices receive a great deal of mail from people who feel their insurance companies are unfairly refusing to pay what they describe as legitimate claims. For example, a woman in Washington, D.C. learned that promised coverage set forth in the large print of her policy was effectively nullified by the small print on the back of her form. A woman in Illinois did receive some help from her policy when she underwent a mastectomy but the company refused coverage for a broken leg which was caused by the cancer. A man in Virginia received \$750 from his company for his \$12,000 bill. A woman in Ohio suffered a relapse but payment was declined because the company had limited its liability to three years from the date that cancer was first diagnosed.

Another example is the woman from Phoenix City, Alabama who wrote in January 1979:

I am sending you everything that you need I think to show that American Family Life does not live up to its promises. I bought a cancer policy on October 15, 1971. It was for my husband and myself. I paid \$60 a year for it until this year when it went up to \$76.20. I was told by their agent, a Mr. ———, that as soon as I was found to have cancer, the company would pay all my bills and I wouldn't have to worry about paying for anything . . . (H)e painted a bleak future for me if I had cancer without the policy. I fell for it and even talked my mother into taking it too. I had a hard time getting anything out of them. In fact, I had to turn it over to my son-in-law who is a professor at Tallahassee, Florida University. He had a hard time collecting on it. I am still paying \$100 a month on the bill. The operation was on March 2, 1976.

Sometimes these claims are justified and sometimes they are not. In any case, it is hard to get any real idea of how a company operates from sporadic complaints. Price Waterhouse and Touche Ross con-

ducted broader studies in their market conduct analysis which pointed out severe problems with the nation's largest cancer insurers.

*Additional support*

1. Price Waterhouse found that there were significant errors in the determination and payment of claims. In 20.8 percent of the cases in their sample, benefits were not determined in accordance with policy terms and in 11.2 percent of the cases, explanation of benefit letters were incomplete as to the additional benefits which would be available to the insured upon the submission of additional documents. In addition, "Complaints from 13 policyholders involving twenty separate claim matters resulted in additional payments by the Company to the insured in six instances." Six errors out of 20 claims reveals an error rate of 30 percent.

2. Attorney William Baldwin noted these same problems in his report. He said the company disputed the 20.8 percent figure saying that its rate of error for not paying benefits in agreement with the policy terms was only 16.8 percent. Baldwin concludes:

The practices employed by the Company tend to cause an undesirable level of errors of omission, which appear to constitute unfair methods of competition, as defined in Chapter 176D of the General Laws.

3. Touche Ross analyzed 5,335 Union Fidelity claims and learned that 1,119 or 21 percent of them were denied in a year. Of 72 paid claims, the average payment was \$330. Most of the unpaid claims are rejected because the claim is not covered in the terms of the policy.

**CONCLUSION (31): THERE ARE SERIOUS SHORTCOMINGS  
IN THE PROCEDURES FOR RESOLVING COMPLAINTS  
AMONG MAJOR CANCER INSURERS**

*Support*

1. Attorney William Baldwin pointed out the following shortcomings with respect to American Family's procedures for resolving complaints:

- No record of telephone inquiries kept.
- The Department does not retain written complaints in a system that would enable retrieval of those complaints.
- The State and District Managers and Agents do not keep records of complaints received by them.
- Claim-related complaints are routed directly to the claims department with no further follow-up by policyholders services.

2. Price Waterhouse reached the same finding with respect to American Family, noting that some complaints never even reach the company's home office:

We noted one formal complaint against an agent by the Massachusetts office of the District Attorney, apparently never forwarded to the home office, dated January 6, 1977,

which revealed a number of calls from elderly citizens stating that an agent had represented himself as being connected with or authorized by the Council on Aging, and also complained about a marketing brochure which states that the Company insures 'against' cancer.

3. Coopers and Lybrand said that American Income "does not have any system to insure that policyholder complaints are resolved satisfactorily and on a timely basis."

4. Coopers and Lybrand also criticized Washington National for failure to institute procedures to investigate and resolve complaints.

5. Touche Ross and Company said that Union Fidelity's complaint procedures needed to be strengthened. As an aside, the report notes that all 23 States selected for purposes of their study had complained to the Company about some aspects of its advertising and had requested that Union Fidelity change certain items. Said Touche Ross:

Based upon our observations in these areas, the Massachusetts Division of Insurance should consider recommending that the company implement standardized procedures to insure that all written complaints/inquiries and significant telephone complaints/inquiries are properly recorded, summarized into meaningful categories, and disposed of in a timely manner. A periodic independent review of these activities by responsible Company management might also be an appropriate recommendation from the Division of Insurance.

### **CONCLUSION (32): MANY STATE INSURANCE COMMISSIONERS ARE LAX IN THEIR REGULATION OF CANCER INSURANCE SOLD BY AGENTS**

The Congress has, by and large, left regulation of insurance to the State Insurance Departments. Committee questionnaires to each Department have established that there is little enforcement in the general area of accident and health insurance which includes cancer and dread disease insurance.

Five States said that they have laws or regulations banning cancer insurance: New York, New Jersey, Massachusetts, Connecticut and New Hampshire. Eight additional States said they had regulations which indirectly prohibited sales or allowed sales only under carefully controlled conditions. Several States indicate studies underway and one State, Rhode Island, said dread disease policies were the greatest single problem now facing the department.

Only 15 States answered affirmatively to the question of whether they had ever reprimanded a company or its agents in conjunction with the sale of dread disease insurance.

On the broader subject of health insurance, many States reported never having fined or disciplined a single agent for abuses in the sale of health insurance over the past five years. Four States, Florida, New York, California and Virginia account for over 60 percent of the license revocations. During this same time frame, only 11 States said they had ever disciplined an insurance company.

### **CONCLUSION (33): INSURANCE SOLD BY MAIL AND IN PARTICULAR MAIL ORDER CANCER INSURANCE PRESENTS SPECIAL PROBLEMS AND IS ESSENTIALLY BEYOND THE REACH OF STATE REGULATORS**

As noted in Section VII of this report, insurance companies which market their policies by mail enjoy a competitive advantage over other firms in that they do not have to file their policies with State insurance commissioners and obtain their approval before the policies can be marketed. Typically they do not incur costs from having an office within the State, of posting the necessary bond which is a precondition to doing business, nor do they have to pay commissions to agents.

Because these companies have no legal presence in the State, they are beyond the scope of State regulation. This is particularly true for mail order firms which sell what is called out-of-State group insurance. Typically, a firm will file a master insurance policy and get approval to sell it to some group (i.e. veterans or senior citizens) in one State; thereafter, the solicitations for insurance and policy certificates evidencing a contract of insurance are mailed into every State of the Union. Mail order firms commonly set up phony trusts as a further device to shield them from regulation.

The seriousness of the problem can be measured by reference to the market conduct examination of Union Fidelity Life Insurance Company as completed by the Massachusetts Department of Insurance in early 1979. That study is summarized in Section IV of this report. Yet another reference is the statements from State insurance commissioners who have requested that the Congress step in and help them regulate what is now a no-man's land in between Federal and State authority. The commissioners complain that they are powerless to block the sale of the most outrageous insurance if it comes into their States by mail, and have asked the Congress to require that all policies sold by mail first be filed with and approved by the State commissioner of insurance before they could be sold in each respective State.

#### **SUMMARY**

The evidence is clear and uncontroverted that dread disease policies, particularly cancer insurance policies, have very limited economic value. They are characterized by loss ratios that are well below average which means high profits for the company, low returns for the consumer. The consumers odds are better at the track, at the lottery or with Las Vegas slot machines. Cancer insurers typically return about 40 cents or less of the premium dollar, keeping the 60 cents for themselves in profits, commissions for salesmen and administrative expense.

For about the same amount of money or a little more, a consumer can buy a health insurance policy which provides fairly comprehensive protection against medical costs incurred through illness or accident. As has been said, buying a cancer policy in lieu of adequate comprehensive coverage is the height of folly. Someone offered the analogy that it is like insuring your automobile piecemeal: one policy for the motor, another for the transmission, another for the lights, and so on.

Buying a cancer insurance policy as a supplement to other insurance can also be hazardous. Most people presently have coverage under a

comprehensive insurance plan. If they wish to supplement their coverage they can buy inexpensive wrap-around policies which cover the costs of medical care, regardless of origin. A person who buys a cancer insurance plan as a supplement to his or her Blue Cross/Blue Shield group health insurance plan will find to his chagrin that his benefits under BC/BS will be reduced dollar for dollar by any benefits which are payable under a cancer insurance plan.

What seems clear beyond contradiction is that companies which sell cancer insurance either by mail or through agents rely upon fear tactics. They kindle the fear that Americans have of cancer. Fanning the flames, they offer the salvation of a nebulous cancer insurance policy which most consumers do not understand. These policies are usually inexpensive; this is because cancer policies are calculated to pay out few benefits. All too often policies include unusually restrictive clauses which limit the company's obligation to pay claims.

The long and the short of it is that few people who purchase a cancer insurance policy will ever develop cancer. Fewer still will file a claim. Thus, a small number of policyholders will collect anything at all. The small minority who do collect benefits will average about \$1,000. A miniscule number will collect a substantial sum of money. But even those who do collect a large sum of money are likely to face the prospect that the collection will mean that other insurance companies will reduce what they pay.

Unless past trends are changed, it appears that many disappointed consumers will continue to file complaints with America's major cancer insurers who are likely to continue to give these complaints short shrift. At least those companies which use agents to sell their products can be held accountable by their State Commissioners of Insurance. Mail order firms have free rein.

In the words of one prominent insurance company president, cancer insurance is a rip-off. It is a rip-off unique to the American marketplace. Nor is it an excuse to say that fire insurance is a similar scheme because few collect. There were no fire insurance companies that the Committee could find that brought tragic pictures of houses burning and people losing their lives into the homes of Americans to persuade them that they needed fire insurance.

It is clear to the Committee that the advertisements and policies used by cancer insurers are unjust, unfair, inequitable, misleading and contrary to law and/or public policy.

Moreover, there is absolutely no reason why the sale of cancer insurance should be permitted to America's senior citizens, all of whom have the benefits of Medicare, and most of whom have at least one Medicare supplementary health insurance policy. As this report notes, the sale of cancer insurance policies to the elderly is clearly duplicative, misleading, unfair, and unconscionable.

## IX. RECOMMENDATIONS

There is no doubt that the findings of this report, like its predecessor, "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal," constitutes an indictment of the States' failure to regulate health insurance—the broad umbrella under which both Medicare supplementary and dread disease policies fall. However, even in the face of this apparent lax regulation, the House Select Committee on Aging does not recommend the repeal of the McCarran-Fergusson Act, supplanting the State role in regulating insurance.

The Committee believes the States should continue to have the primary responsibility but also believes it is clear that the Federal government must aid the States in certain areas. Medicare supplementary health insurance is one such area. The Federal government, through the enactment of the national Medicare program, created national problems which can only be addressed at the national level. Therefore, the task confronting the Congress is how to meet its obligations to the nation's 23 million elderly without interfering in the traditional State prerogative to regulate insurance. There are several things which can and must be done, as follows:

### LEGISLATIVE RECOMMENDATIONS

**1. The Congress should require that policies sold to the elderly in supplementation of Medicare provide broad coverage and are not limited to providing protection against the costs of incurring a single dread disease.<sup>1</sup>**

As noted in this report, most of the nation's 23 million elderly and some 4 million disabled participate in the Medicare program, a national health insurance program enacted in 1965. Since most of these people also have one or more additional Medicare supplementary policies, it makes no sense at all for them to purchase a single disease policy. This is particularly true since Blue Cross and Blue Shield—the major sellers of Medicare supplementary policies—frequently coordinate their benefits against cancer insurance policies. This means that for every \$1 paid by cancer insurance, Blue Cross will reduce its coverage by \$1. The Congress should make clear its preference for legitimate full benefit wrap-around policies sold to fill Medicare's gaps, paying for dental care, prescription drugs, eyeglasses and other items not covered by Medicare. The latter would pay medical expenses *regardless* of whether the cause was an accident or any particular disease.

**2. The States should carefully review and upgrade their regulations of cancer insurance with an eye toward providing requisite protections for all Americans.**

<sup>1</sup> As of December 8, 1978, American Family, the Nation's largest cancer insurer, recognized this problem and voluntarily stopped all sales to the elderly. See Appendix V.

These protections could take the form of banning the sale of cancer insurance outright following the lead of New York, New Jersey, Massachusetts, Connecticut and New Hampshire. Another regulatory approach is to require cancer insurers to reach minimum loss ratio standards—that is, require that they return 80 cents on the premium dollar to their insured for insurance sold on a group basis and 70 cents on the premium dollar in the case of individual insurance. State regulations should also require disclosure of the extent of coverage provided by the policy in writing prior to sale, outlaw unfair and deceptive practices such as misrepresenting the chances of contracting cancer and the use of fear as a selling tactic. The regulations should require payment of claims on a timely basis and allow an aggrieved policyholder to go into court and receive treble damages if it can be proved that the company knowingly and purposely withheld payment on legitimate claims for an excessive period of time or failed to pay claims altogether.

**3. Congress should act to aid the States in regulating mail order insurance.** This is the one area where State commissioners of insurance have been nearly unanimous. Section 11 of Chairman Pepper's bill, H.R. 2602, sponsored by a majority of this Committee and 265 Members of the House (S. 1295 in the Senate introduced by Senators Baucus and Culver) was included at the suggestion of the State insurance commissioners. Some 38 of them have written of their support of provisions which would require that all policies sold by mail must first be filed with and approved by the commissioner of insurance of the respective State before they can be sold in that State. By enacting this provision, Congress would be strengthening the hand of State commissioners and not supplanting their authority. By doing so, the Congress would close a loophole which presently permits unconscionable policies to be marketed by mail to the elderly and others.

**4. Congress should act to make certain common abuses perpetrated by insurance agents illegal.** There is presently no law which makes it illegal for an insurance agent to represent himself as an employee of the Department of Health, Education, and Welfare or of the Medicare program. Nor is there any Federal law which prohibits an agent from selling multiple, unneeded and duplicative insurance which he knows are not in the best interests of a prospective client. Similarly, there is no Federal law which prohibits the most common of abuses known as "twisting" which involves an agent causing a client to drop an existing policy in favor of his policy when the only reason for doing so is to permit the agent the high commission which goes with new policy sales.

In view of the fact that 44 States told the Congress that "twisting" and deliberate overselling of policies were serious problems and the fact that 34 more States responded that they had a serious problem with agents representing themselves as being from the Medicare program, action by the Congress appears to be long overdue. These reforms are included in H.R. 2602.

## ADDITIONAL VIEWS OF MR. GRASSLEY

The committee investigation of this subject makes clear that there are abuses in the sale of dread-disease insurance policies and that the elderly are especially susceptible to these abuses. It is in the belief that such abuses should be exposed and corrected that I endorse the committee report.

At the same time, I wish to observe that among the agencies selling this type of insurance are honest companies that portray their product in accordance with good business principles. The questionnaire used by the committee to obtain an assessment of the industry tends to obscure this fact since the yes-nor-no answers it requires leave little latitude for modified responses unless, as in the case of Bankers Life of Des Moines, Iowa, the respondent ignores the discipline of the questionnaire and provides a reasoned response.

With respect to the legislative recommendations of the report, I reaffirm the basic view that the authority for the regulation of insurance sold within a State should rest with the State and not with the Federal Government. This is not to express unqualified disagreement with the recommendations, but to contend that they should be subject to close examination under this principle prior to final adoption.

CHARLES E. GRASSLEY.

**SUPPLEMENTAL VIEWS OF REPRESENTATIVE  
JOHN PAUL HAMMERSCHMIDT**

I wish to commend Chairman Pepper and his staff for this comprehensive report on cancer insurance. It is clear from a review of the report that a broad array of investigative paths were taken in studying this issue.

Although the conclusions of the report are firmly weighted in findings by the GAO, FTC, and investigations by numerous State insurance departments, I believe that the questionnaire submitted to the 50 State insurance commissioners and insurance companies lacked a certain amount of objectivity. For example, question 1 states, "Do you agree that dread disease policies have very limited economic value?" In addition, the binary mode limited respondents to "yes" or "no" answers. Whether or not one believes that dread disease insurance has economic value may require a more complex reply. In fact, the response from the insurance department in Arkansas, the State I represent, began, "I do not feel I may answer all of these questions with simply a 'yes' or 'no' ". A wider range of options might have elicited different and more precise information.

On the balance, it seems to me that this bias was neutralized by the force of the other evidence. However, in future reports I hope the procedures used to accept or reject a hypothesis would be designed to minimize bias as much as possible.

**JOHN PAUL HAMMERSCHMIDT.**

**ADDITIONAL VIEWS OF REPRESENTATIVE  
RALPH S. REGULA**

Recognizing that regulation of the insurance industry is a State and not a Federal function, I recommend the printing of this report on the condition that it be immediately transmitted to each State insurance commissioner and to any other State or local agencies who can use the valuable information contained in the report to implement the changes that will halt the abuses described in the report.

APPENDIX I

COMMITTEE QUESTIONNAIRE ON DREAD DISEASE INSURANCE  
SENT TO ALL STATE COMMISSIONERS OF INSURANCE

**U.S. House of Representatives**  
**Select Committee on Aging**  
**Washington, D.C. 20515**

TELEPHONE 622-2647

CLAUDE PEPPER, FLA.  
CHAIRMAN

BERNARD R. ROYBAL, CALIF.  
FRID S. ROONEY, PA.  
HAROLD BASS, N.Y.  
WALTER FLORES, ALA.  
KEE F. ANDRUSSE, N.C.  
JOHN L. BURTON, CALIF.  
KENNEDY P. USARD, N.J.  
MICHAEL T. BLOUNT, IOWA  
DON BRIDGER, WASH.  
THOMAS J. DONNEY, N.Y.  
JAMES J. FLORIO, N.J.  
HAROLD E. FORD, TENN.  
WILLIAM S. HARSHBARGER, N.J.  
MARGALYN LLOYD, TENN.  
JIM BARTNER, NEV.  
TED BISHOP, OHIO  
ROBERT F. DANAHAN, MASS.  
DAVID W. EVANS, IND.  
HELEN S. HAYTHE, N.J.  
MONTY RUBIN, N.J.  
STANLEY R. LINDBERG, N.Y.  
BOBBY ROSE GASKAR, OHIO  
WILLIAM C. WAMPLER, VA.  
RANKING MINORITY MEMBER  
JOHN PAUL HANSEN, ARIZ.  
WILLIAM S. COHEN, MASS.  
RONALD A. SARABAN, CONN.  
CHARLES E. GRASSLEY, IOWA  
JAMES ANCHOR, S. CAR.  
THOMAS COCHRAN, MISS.  
MCKYTHEN J. PERALDO, N.J.  
BARRY L. MARPER, PA.  
RALPH E. RUSSELL, OHIO  
JOHN B. LACRO CURRIENHAM, WASH.

ROBERT S. WEISER  
STAFF DIRECTOR  
JAMES A. BREWSTER  
ASST. TO THE CHAIRMAN  
EDWARD F. HOWARD  
GENERAL COUNSEL  
VAL J. MALAMANDARIS  
SPECIAL COUNSEL  
WALTER A. BURTHOFF, Ph.D.  
SECURITY STAFF DIRECTOR

December 6, 1978

Dear Mr. Commissioner:

During the last few weeks, I have written to you and all the other State insurance commissioners, asking for assistance. I have been most gratified by your prompt and detailed response. The culmination of this correspondence was our hearings on this subject which received wide publicity last week.

Once again, I am calling upon you for assistance. One issue which was raised at our recent hearings and deserves further investigation is the subject of dread disease policies. In its June 1978 edition, CONSUMER REPORTS contends that dread disease policies have limited economic value, that fear tactics are often used to sell such insurance and that most people are better off improving their comprehensive coverage rather than buying single disease policies. It is noted that these policies are banned in three states and a Professor at the Wharton School of Economics is quoted as saying, "Cancer insurance is as close to being a worthless product as you can find. It is an embarrassment to the insurance industry." Copy of the article enclosed.

I would like to solicit your opinions on each of these statements. Would you be kind enough to answer the questions listed below and return this letter to me at your earliest convenience. Your response is most important. Please indicate if you would be willing to testify before the Committee at any future hearings.

1. Do you agree that dread disease policies have very limited economic value?  Yes  No
2. Do you agree that they are close to being a worthless product?  Yes  No
3. In your experience, have you ever found that companies selling these products employ fear tactics to promote their policies?  Yes  No

4. Do you agree that most people would be better off if they improved their comprehensive coverage as opposed to buying a single disease policy?  Yes  No
5. Have you ever reprimanded a company (or its agents) in conjunction with the sale of dread disease policies?  Yes  No  
If yes, which company, when and why? Please enclose copies of any pertinent documents.
6. Would you be willing to testify before the House Select Committee on Aging on this subject?  Yes  No

We welcome any additional comments you may have to offer.

With warm regards, and

Believe me,

Always sincerely,

Claude Pepper  
Chairman

CP:vhs

APPENDIX II

COMMITTEE QUESTIONNAIRE ON DREAD DISEASE INSURANCE  
SENT TO THE TOP 50 HEALTH INSURANCE COMPANIES

CLAUDE PEPPER, FLA.  
CHAIRMAN

EDWARD R. ROYBAL, CALIF.  
FRID S. ROONEY, PA.  
MARIO BARRI, N.Y.  
WALTER FLORINS, ALA.  
ICE F. ARONSON, N.C.  
JOHN L. BURTON, CALIF.  
EDWARD P. BARNARD, N.J.  
MICHAEL T. BLUMENTHAL, IOWA  
DOR BORSCH, WASH.  
THOMAS J. CONNERY, N.Y.  
JAMES J. FLORIO, N.J.  
HAROLD E. FORD, TEXAS  
WILLIAM J. HARRIS, N.J.  
RUSSELL W. LLOYD, TEXAS  
JIM BARTON, NEV.  
TED STEINBOCK, OHIO  
ROBERT F. DUNNAN, MASS.  
DAVID W. EVANS, MD.  
HELEN S. MEYER, N.J.  
SHIRLEY BURNS, N.J.  
EDMUND H. LUNDINE, N.Y.  
RUBY ROSE GASKAR, OHIO  
WILLIAM C. WAMPLER, VA.  
RANKING MINORITY MEMBER  
JOHN PAUL HAMMERSCHMIDT, ARIZ.  
WILLIAM S. COHEN, MASS.  
RONALD A. BARABEE, CONN.  
CHARLES E. GRASSLEY, IOWA  
JAMES ARNOLD, S. DAK.  
THOMAS COCHRAN, MISS.  
MATTHEW J. RINALDO, N.J.  
FRANC L. BARNES, PA.  
RALPH S. HIRSULA, OHIO  
JOHN E. LACRO GLENNINGHAM, WASH.

**U.S. House of Representatives**  
**Select Committee on Aging**  
**Washington, D.C. 20515**

TELEPHONE 555-3347

ROBERT S. WEBER  
STAFF DIRECTOR  
JAMES A. BRIDGES  
ASST. TO THE CHAIRMAN  
EDWARD F. HOWARD  
GENERAL COUNSEL  
VAL J. MALAMANDARI  
SPECIAL COUNSEL  
WALTER A. GUNTHER, Ph. D.  
MINORITY STAFF DIRECTOR

December 6, 1978

Dear Mr. \_\_\_\_\_:

Some time ago, I asked for your assistance with respect to the issue of Medicare supplementary health insurance. We were most grateful for your responses. The result of that inquiry was a hearing at which we disclosed the fact that we had found a minority of insurance companies (or their agents) were over-selling policies to senior citizens. We took pains to point out that the vast majority of companies were not involved in these abuses.

Once again, I am calling upon you for assistance. One issue which was raised at our recent hearings and deserves further investigation is the subject of dread disease policies. In its June 1978 edition, CONSUMER REPORTS contends that dread disease policies have limited economic value, that fear tactics are often used to sell such insurance, and that most people are better off improving their comprehensive coverage rather than buying single dread disease policies. It is noted that these policies are banned in three states and a Professor at the Wharton School of Economics is quoted as saying, "Cancer insurance is as close to being a worthless product as you can find. It is an embarrassment to the insurance industry."

I would like to solicit your opinions on each of these statements. Would you be kind enough to answer the questions listed below and return this letter to me at your earliest convenience. Your response is most important.

1. Do you agree that dread disease policies have very little economic value?  Yes  No

2. Do you agree that they are close to being a worthless product?  Yes  No
3. Do you believe that companies selling these products employ fear tactics to promote their policies?  Yes  No
4. Do you agree that most people would be better off if they improved their comprehensive coverage as opposed to buying a single dread disease policy?  Yes  No

We welcome any additional comments you may have to offer. Please return this letter along with any supplemental material to me at the following address:

Select Committee on Aging  
3475 House Annex #2  
Washington, D.C. 20515

Your assistance in this study will be most appreciated.

With warm regards, and

Believe me,

Always sincerely,

Claude Pepper  
Chairman

CP:vhs

APPENDIX III

COMMITTEE QUESTIONNAIRE ON MAIL ORDER INSURANCE SENT TO ALL STATE COMMISSIONERS ON INSURANCE

U.S. House of Representatives  
Select Committee on Aging  
Washington, D.C. 20515

TELEPHONE (202) 555-6875

ROBERT S. WEINER  
STAFF DIRECTOR  
JAMES A. BRENNAN  
ASST. TO THE CHAIRMAN  
EDWARD F. HOWARD  
GENERAL COUNSEL  
VAL J. MALAMANDARIS  
SPECIAL COUNSEL  
WALTER A. BARTHLEPP, PH. D.  
IDENTITY STAFF DIRECTOR

- CLAUDE PEPPER, FLA.  
CHAIRMAN
- BERNARD R. D'AMICO, CALIF.
- DAVID BARNES, N.Y.
- W. F. ANDREWS, D.C.
- JOHN L. BURTON, CALIF.
- BOB BROWDER, WASH.
- THOMAS J. DONOHUE, N.Y.
- JAMES A. FLORIO, N.J.
- ARNOLD S. PERRY, TEXAS
- WILLIAM J. HUGHES, N.J.
- ROBERT W. LLOYD BENDISSE, TEXAS
- JOE BARTER, NEV.
- ROBERT F. DODDAM, MASS.
- DAVID W. EVANS, IND.
- DAVID HENDER, S.C.
- FRANKLYN H. LAWRENCE, N.Y.
- BOBBY ROSE DAKAR, MISS.
- ELIZABETH HILL-TYSON, N.Y.
- JOE LLOYD, CALIF.
- THOMAS A. LARSEN, MISS.
- WES WATSON, OKLA.
- LEAHAN GARDNER, N.C.
- BERNARDINE A. PETERSON, N.Y.
- BERNARD S. GYFFORD, MD.
- WILLIAM B. BATHENFORD, OHIO
- BOB HICKS, FLA.
- BERNARD A. STONE, FLA.
- HERBY A. WALKER, CALIF.
- EDWARD L. VAN SWAN, OKLA.
- BERNICE V. ATKINSON, PA.
- CHARLES E. BRADLEY, IOWA
- FRANKLIN BARNETT HERRICK
- WILLIAM C. WAMPLER, VA.
- JOHN PAUL HAMMERSTROMBY, ILL.
- JAMES GARDNER, S. DAK.
- MATTHEW J. BOWLES, N.J.
- DAVID L. MARSH, PA.
- RALPH S. MARSHALL, MISS.
- BOB WY H. DODMAN, CALIF.
- MARCEL C. HOLLANDER, S.C.
- S. WILLIAMS GREEN, N.Y.
- ROBERT (BOB) WHITTAKER, MISS.
- BERNARDINE H. HERRINGTON, CALIF.
- LARRY J. HOPKINS, N.Y.
- OLYMPIA A. GROSS, MASS.
- BRUCE S. LAWRENCE, CALIF.

October 5, 1979

Dear Mr. Commissioner:

As you may know, the House Select Committee on Aging has been concerned with abuses in the sale of health insurance to the elderly. We have written to you and the other State insurance commissioners who are generally skeptical of federal regulation except in one area. We have been invited to help regulate mail order (particularly out-of-state group) supplementary policies.

The New York Commissioner testified about the increasing use of phony trusts "set up for the sole purpose of selling a policy by mail where the policy, that is the certificate, is delivered to the trust." He said that the Congress could step in here and provide a valuable service without getting involved in the State's efforts to regulate insurance by saying, in effect,

"If it is not a proper policy that could be sold in the State, it should not be sold through the U.S. mail. That would be legislation that I would welcome and would still leave to the State the responsibility to control the type of traffic or commerce in insurance policies within the State."

The purpose of this letter is to ask whether you would support legislation which requires that medicare supplementary policies including group insurance be first filed with your office and approved before policies or certificates could be sold in your State. I am considering offering this amendment to a pending Medicare reform bill and I need your advice as soon as possible.

Could you support the following language:

Whoever knowingly advertises, solicits, or offers for sale by mail, or knowingly deposits in the mail or sends or delivers by mail any insurance policy or policy certificates in

supplementation of Medicare in any State in which said individual or group policy or policies have not been approved by the State commissioner or superintendent of insurance shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years or both.

Could you return this letter with your answers to the questions listed below to me at 434 Cannon House Office Building, Washington, D.C. 20515 as soon as possible?

I appreciate your cooperation.

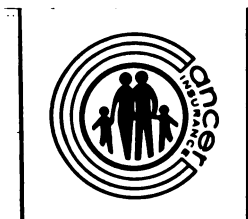
Sincerely,

Don Bonker

---

1. Would you support the enactment of the language above which would require mail order supplementary policies (including out-of-state group insurance) to be filed with the commissioner of insurance of the respective State before being sold in that State?  Yes  No

2. Would you support the extension of this language to cover all health insurance instead of only policies sold in supplementation of Medicare?  Yes  No



APPENDIX IV

PETER D. MORROW  
Vice President  
Director of Marketing

american family life assurance company of columbus  
home office, columbus, georgia 31902, telephone 404 323-3431

December 8, 1978

TO: ASSOCIATES AND MANAGERS

Please suspend immediately all direct sales of cancer insurance to people 65 years of age and older pending further study. This restriction does not apply to employer/employee accounts.

All applications received after December 21, 1978 will be rejected and returned.

  
Peter D. Morrow

PDM/jh

## APPENDIX V

JOHN F. SEIBERLING  
147th District, Ohio

COMMITTEE  
JUDICIARY  
INTERIOR AND  
INSULAR AFFAIRS

**Congress of the United States**  
**House of Representatives**  
Washington, D.C. 20515

WASHINGTON OFFICE:  
1225 LONGWORTH HOUSE OFFICE BUILDING  
TELEPHONE (202) 225-8231

DISTRICT OFFICE:  
FEDERAL BUILDING  
AKRON, OHIO 44308  
TELEPHONE: (216) 276-5710

September 11, 1979

Hon. Claude Pepper  
Chairman, Select Committee on Aging  
HOB Annex II, Room 3269  
U.S. House of Representatives

Dear Mr. Chairman:

I am enclosing correspondence and other materials related to a constituent inquiry about the practices of an insurance company which sells an old-age supplemental insurance plan under the name of "Medicare A-plus 5."

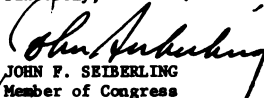
It is my opinion that the use of "Medicare" in the name of this plan is misleading, and could induce elderly persons to purchase this insurance plan under the assumption that it is part of the federal health insurance program for retired persons (commonly known as "Medicare"). Since the federal Medicare program designates hospital coverage as part "A" insurance, I am concerned that the solicitation to buy "Medicare A-plus 5" would easily lead an elderly person to this assumption.

I understand that your Committee is considering HR 2602, which I have cosponsored, to set voluntary standards for private insurance plans which intend to supplement federal Medicare coverage. I believe it is necessary to add a provision to this legislation to prohibit insurance companies from employing the term "Medicare" in the descriptive title of their "medi-gap" insurance plans to assure that elderly persons are not deceived about the relationship of these supplemental plans to the federal health insurance program. I urge you to add such a provision to HR 2602.

I would appreciate receiving your comments and recommendations on this matter. Thank you for your attention.

Best regards,

Sincerely,

  
JOHN F. SEIBERLING  
Member of Congress

JFS:eg  
enclosure

August 9, 1979

Refer to: HI:DS

Mr. Joseph J. McGee, Jr., President  
 Old American Insurance Company  
 4900 Oak Street  
 Kansas City, Missouri 64111

Dear Mr. McGee:

Our office has recently received a complaint from Congressman John Seiberling of Ohio regarding the attached promotional material used by your company. The complaint states that the material is misleading in that it leads the recipients of the material to believe that they are dealing with the Federal Government or that the Government endorses the coverage.

We agree with the complaints that the likely purpose in the use of the word Medicare either in the title of a company or in its promotional material is to give the impression that the products or services offered are endorsed or approved by the Federal Government.

We feel very strongly that our Medicare beneficiaries should not be misled in any way when they are considering the purchase of a private insurance policy to supplement their Medicare coverage. We would therefore ask you to consider not using the word Medicare so prominently in your promotional material. If your agency feels this cannot be accomplished we request that your literature regarding supplemental Medicare policies prominently display a disclaiming statement to the effect that your policy is not affiliated with, or endorsed or approved by, the Federal Government.

We would appreciate a written response within twenty days outlining what your agency's plans are in this area so that we may respond to Congressman Seiberling. The written response should include time frames in which the changes in your promotional material will be completed.

We would like to thank you in advance for your anticipated cooperation in this matter. If you have any questions, feel free to contact Gary Smith of my staff at (312) 353-3591.

Sincerely,

David Wells  
Director  
Division of Program Management  
Medicare Bureau

Attachment

GSmith:kc

DF-E-1

**(A) OLD AMERICAN INSURANCE COMPANY**

4900 OAK STREET • KANSAS CITY, MISSOURI 64141 • (816) 753-4900

August 27, 1979

David Wells, Director  
Division of Program Management  
Medicare Bureau  
Department of Health, Education and Welfare  
Regional Office V  
175 West Jackson Blvd.  
Chicago, Illinois 60604

RE: HI:D8

Dear Mr. Wells:

Mr. McGee has asked that I reply to your letter of August 9, 1979.

We are indeed concerned that Congressman Seiberling feels that our promotional material is misleading. However, I must respectfully disagree with his office with respect to the advertising material enclosed with your letter of August 9th.

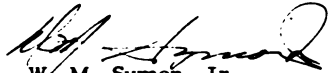
We agree with you that Medicare beneficiaries should not be misled when considering the purchase of insurance to supplement Medicare. However, I find it difficult to understand how we can sell a product which supplements Medicare without mentioning Medicare. I have been in attendance at perhaps a dozen hearings in state insurance departments regarding the sale of Medicare supplement policies. It is evident to me that the problem arises because of the few unscrupulous agents who take advantage of the older people in the sale of these types of products. However, I think you must admit that our sales brochure very clearly states what Medicare pays, what Medicare does not pay, and what Old American's policy does pay.

We have never felt that any disclaimer is necessary when we make no affirmative statement to the effect that our company is in any way affiliated with Medicare. After all, it is the deficiencies in the

Medicare program which give rise to the need for Medicare supplement policies in the first place. I fully realize that rising hospital costs create the need for raising the deductible every year - thus increasing the need, which the older people have, for Medicare supplement types of coverages.

The promotional material to which Congressman Seiberling's office refers has been in use for sometime in many states throughout the United States. It has never been subjected to the type of criticism contained in your letter. In view of this, we see no reason to change any of our promotional material. It is my personal opinion that we comply fully with the National Association of Insurance Commissioners advertising rules for Accident and Sickness Insurance which are now in force in many states throughout the country. We appreciate your calling this to our attention, but under the circumstances we see no necessity for making any changes.

Sincerely,



W. M. Symon, Jr.  
Secretary and General Counsel

WMSJr/lb

SEP 10 1979



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
REGION V

175 W. JACKSON BOULEVARD  
CHICAGO, ILLINOIS 60604

HEALTH CARE FINANCING  
ADMINISTRATION

September 5, 1979

Refer to: HI:D8

Honorable John Seiberling  
Member, House of Representatives  
Washington, D.C. 20510

Dear Mr. Seiberling

Re: Bernice Haufe

(Your Inquiry Dated June 26, 1979)

This is the final response to your inquiry regarding Ms. Haufe's concern about the promotional material she received from Old American Insurance Company.

A member of my staff contacted the President of Old American Insurance Company asking them to consider altering their promotional material. I am attaching a copy of our letter and a copy of the response we received from Old American Insurance Company.

When the original legislation was enacted in July 1965 there were no statutory references to the word "Medicare". The official title of the original enactment, P.L. 89-95, was "Health Insurance for the Aged Act". After enactment, the media attached the word "Medicare" to the programs and we increasingly used that term in program public information activities. In view of the lack of statutory designation, the Federal Government has no proprietary privilege in the use of this term and cannot prohibit its commercial use.

Recognizing, however, that use of the word "Medicare" in a private insurance companies promotional material can create the inference of affiliation with, or special status under, the Federal Medicare program, we sent the attached letter to Old American Insurance Company. The response indicates that they do not wish to alter their promotional material, and therefore there is nothing more that my office can do.

I would suggest that Mr. Haufe contact the appropriate Missouri State agencies such as the State Insurance Commissioner or the State Consumer Protection Agency.

I am happy to have been of assistance.

Sincerely,

*Robert A. Cullen*

Robert A. Cullen  
Regional Medicare Director

Enclosure

9

CLAUDE PEPPER, FLA.  
Chairman

EDWARD B. BONNER, CALIF.  
 ERNEST BURNER, N.Y.  
 JIM P. ANDERSON, ILL.  
 JOHN L. SWINNEY, CALIF.  
 BOB DUNCAN, WASH.  
 THOMAS A. BURNETT, N.Y.  
 JAMES A. FLORIO, ILL.  
 HAROLD D. PETER, TEXAS  
 WILLIAM J. MARSHALL, ILL.  
 RICHARD LLOYD HENNINGSEN, WASH.  
 JIM BARTON, IND.  
 ROBERT F. BRADLEY, MICH.  
 RICHARD M. COCHRAN, ILL.  
 DONALD W. LAMSON, ILL.  
 RICHARD M. ROBERTS, ILL.  
 GLENN THOMPSON, ILL.  
 JIM ALDRY, CALIF.  
 THOMAS A. LUKE, OHIO  
 BOB WITTLING, OHIO  
 LAWRENCE GORDON, ILL.  
 EDWARD J. FEENEY, ILL.  
 DONALD W. RITCHIE, OHIO  
 BOB MOCA, FLA.  
 ROBERT A. WICKS, FLA.  
 DONALD LLOYD HENNINGSEN, WASH.  
 CHARLES E. GRASSLEY, IOWA  
 FRANCINE MINORITY MEMBER  
 WILLIAM C. WAMPLER, W.V.  
 JOHN POSE, MICHIGAN, ASST.  
 JAMES ARNONE, S. DAK.  
 MATTHEW J. WHELAN, ILL.  
 ERIC L. BARRIS, PA.  
 BRUCE S. BELLINGER, ILL.  
 ROBERT H. COCHRAN, CALIF.  
 DONALD G. HOLLANDER, ILL.  
 S. WILLIAM WOOD, N.Y.  
 ROBERT ERIC WYATT, MICH.  
 ROBERT D. BRADLEY, CALIF.  
 LARRY J. HORNUNG, ILL.  
 OLIVER A. BROWN, IOWA  
 DONALD W. LAMSON, CALIF.

**U.S. House of Representatives**  
**Select Committee on Aging**  
**Washington, D.C. 20515**

Telephone (202) 555-4075

September 18, 1979

Honorable Bill Gunter, Commissioner  
 Department of Insurance  
 The Capitol  
 Tallahassee, FL 32304

Dear Bill:

In the past you have been of great assistance to this Committee in its efforts to protect the elderly from unscrupulous practices by insurance agents and companies alike. I wish to thank you for this invaluable contribution and to once again ask for your input.

Recently, Congressman John Seiberling of Ohio has brought to our attention certain advertising materials used by the Old American Insurance Company (4900 Oak Street, Kansas City, MO 64141). In short, Mr. Seiberling is concerned that this company's medigap policy called "Medicare A - Plus 5" as well as its advertising materials are potentially misleading to senior citizens. He, along with one of his constituents specifically object to use of the word "Medicare" in this product's title.

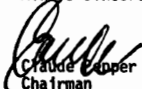
Having examined the material in question, I am inclined to agree with Mr. Seiberling. May we have the benefit of your expert judgment on this issue?

Enclosed are copies of the company's advertising materials. Would you review them and advise me whether or not you find them misleading. I would appreciate your commenting as to whether you think these company with the NAIC guidelines as well. Are you in a position to regulate these practices? Any other insight you can provide would be welcome.

With kindest personal regards, and

Believe me,

Always sincerely,

  
 Claude Pepper  
 Chairman

CP:dhs

Enclosure

ROBERT S. WELCH  
 STAFF DIRECTOR  
 JAMES A. BRIDGMAN  
 ASST. TO THE CHAIRMAN  
 EDWARD F. HOWARD  
 GENERAL COUNSEL  
 WIL J. HALLAMANN  
 OFFICE MANAGER  
 WALTER A. BRANTHART, JR. D.  
 SENIORITY STAFF DIRECTOR

*Bill Gunter*  
 STATE TREASURER  
 INSURANCE COMMISSIONER  
 FIRE MARSHAL



*Office of Treasurer.*

*Insurance Commissioner*

STATE OF FLORIDA

TALLAHASSEE 32301

October 23, 1979

Honorable Claude Pepper  
 Chairman  
 Select Committee on Aging  
 United States House  
 of Representatives  
 712 Annex One  
 Washington, D.C. 20515

Dear Senator:

Reference is made to your letter of September 18 concerning the advertising materials used by the Old American Insurance Company as brought to your attention by our mutual friend, the Honorable John Seiberling of Ohio.

Please find enclosed a copy of a letter sent January 18 by Mr. George D. McDonald, Chief of our Bureau of Life and Health Insurance, to Mr. Joseph J. McGee, Jr., President of Old American Insurance Company.

You will see that we objected strenuously to the "Medicare A-Plus 5" sales material mailed into the State of Florida. We definitely did find them misleading for the reasons cited in the correspondence.

The company has not attempted further sale of this policy in Florida, and our Department is insisting that any future Medicare supplemental policy marketed by the firm be submitted first to our Department for inspection. As these comments would indicate, we most definitely do feel that the advertising materials do not comply with the guidelines as set out by the National Association of Insurance Commissioners. Florida's Advertising Rule 4-6

Honorable Claude Pepper  
October 23, 1979  
Page Two

parallels the NAIC model. Additionally, we are currently studying the new proposed Medicare Supplement Model advanced recently by the NAIC.

I cannot commend you enough, Senator, for your uncompromising dedication to exposing abuses whenever you find them perpetrated against this country's older Americans.

Kind personal regards,



Bill Gunter  
State Treasurer and  
Insurance Commissioner

BG/Pn  
Enclosure  
cc: Mr. George D. McDonald

*Bill Hunter*  
 STATE TREASURER  
 INSURANCE COMMISSIONER  
 FIRE MARSHAL



*Office of Treasurer*  
*Insurance Commissioner*  
 STATE OF FLORIDA  
 TALLAHASSEE 32304

January 18, 1979

Mr. Joseph J. McGee, Jr.  
 President  
 Old American Insurance Company  
 4900 Oak Street  
 Kansas City, Missouri 64141

Dear Mr. McGee:

Your company is offering a policy entitled Medicare A-Plus (form ID 3044).

We have recently received a copy of sales material sent to a Florida resident and in our review find this material violates several sections of our Rule and Statutes.

1. We have never permitted the use of "Enroll" except in the case of group coverages. These applicants are not "enrolling" in anything; they are applying for a policy on an application form, not an "enrollment" card.

This objection was brought to the company's attention during your filing of the form for approval in 1976. Corrections were made and since these objections are now in use; this violates the approval that was given.

2. The use of the reference "You must be the individual designated on the enclosed non-transferable certificate", in order to qualify. This is misleading and misrepresents the type of solicitation made to residents. (Section 626.9541(2)).

This requirement (shown as #1), contradicts the Question and Answer entitled "Who is eligible

Mr. Joseph J. McGee, Jr.  
January 18, 1979  
Page Two

for Medicare A-Plus"? The answer indicates that "everyone who lives in a state to which this letter was mailed" is eligible. Requirement #1 implies limited eligibility (Section 626.9541(1) and (2)). Further, the Department prohibits the reference to "certificates" in connection with individual coverages, since certificates denote a group type coverage. This "reservation Certificate" has not been approved and is misleading. (Section 627.410 and 626.9541(2)).

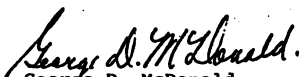
3. You referred to "Important: Regardless of your decision, it is essential that we have your "Yes" or "No" answer, etc.". This tends to place undue pressure on the applicant and uses tactics to create a fear that causes Senior Citizens to believe they will loose out on this deal unless they take affirmative action. We feel that this is unfair to them and not in their best interest.
4. The material includes an application Form ID 2096 which (according to our files) has never been filed for approval and is in violation of Rule 4-6.17 in that it does not contain the agent's name or space for his signature.
5. Finally, it appears that your loss ratio on this business is approximately 24% and represents a premium structure which is not reasonable in relation to the benefits provided. (Section 627.411(5)). Mr. Don Nettles, of our Bureau, called Mr. Bob Swanson of your company on January 5, and requested

Mr. Joseph J. McGee, Jr.  
January 18, 1979  
Page Three

certain statistical information regarding this policy which was to be furnished by January 12. The information sent was not for Florida business only as requested and further information was to be submitted.

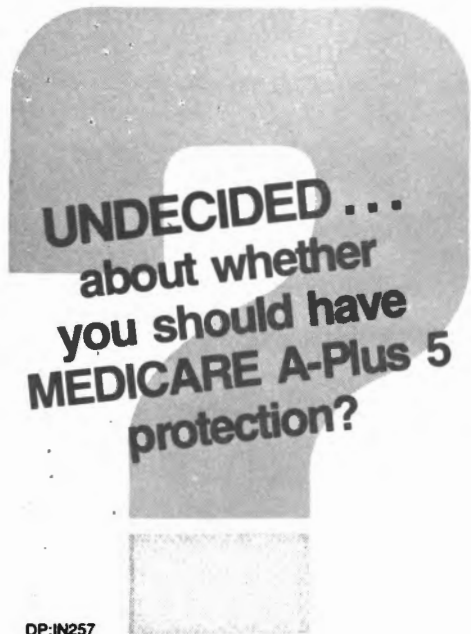
Therefore, you are advised that any further use of this sales material is prohibited and based upon the above mentioned violations, you will be given until February 18, to show cause why approval of this policy should not be withdrawn.

Sincerely yours,

  
George D. McDonald  
Chief, Bureau of Life  
and Health Insurance

GDMcD:lk

57-614-006



## Take 10 DAYS to decide... while you are fully protected!

Send for your policy today. When you receive it, look it over carefully. Show it to anyone you wish. Consider all the benefits. Don't rush yourself. Take up to 10 full days to make up your mind.

If you decide to keep the policy, there's nothing more you need to do. It will stay in force, protecting you. If you decide not to keep it, just send it back and we'll refund your premium in full — no questions asked!

**EITHER WAY, YOU'LL BE PROTECTED THOSE 10 DAYS!**

*So don't pass up this can't-lose offer. Apply today.*

**OLD AMERICAN INSURANCE COMPANY**

4900 OAK STREET • KANSAS CITY, MISSOURI 64141

# MEDICARE A-PLUS 5 RESERVATION CERTIFICATE

Use this reservation  
to tell us

**"YES" or "NO"**

... but please mail it  
before the deadline  
shown below

**YES**

I (and my spouse if I have so indicated) wish to enroll in the MEDICARE-A-Plus 5 Insurance Plan, and have filled in the information requested below.

**NO**

I do not wish to take advantage of this opportunity, and understand I waive my eligibility for guaranteed issue of the MEDICARE A-Plus 5 policy until such time as enrollment may be opened in my state once again.

## ENROLLMENT FORM FOR MEDICARE A-Plus 5

**OLD AMERICAN INSURANCE COMPANY:** Please enroll me (and my spouse if named below) in the MEDICARE A-Plus 5 plan of insurance at \$9.50 per month per person.

PERSONS TO BE INSURED			DATE OF BIRTH		
First Name	Middle Initial	Last Name	Month	Day	Year
SELF } _____			Month	Day	Year
SPOUSE } _____			Month	Day	Year

DATE \_\_\_\_\_  PAYMENT ENCLOSED \$ \_\_\_\_\_  
Month Day Year

NON-TRANSFERABLE — OFFER VALID ONLY FOR:

I understand this enrollment form must be mailed by the deadline date and that the policy (Series ID3044 or ID3050) shall take effect upon its execution at the Company's home office.

SIGNATURE  \_\_\_\_\_  
First Name Middle Initial Last Name

9A/A417  
BERNICE G HAUFE  
432 HIGHGROVE VL  
AKRON OH 44312

1279

**ENROLLMENT FORM  
MUST BE MAILED BY... JUNE 4, 1979**

ID2096 Old American Insurance Company / 4900 Oak St., K.C., Mo 64141

DP-AP687-SA

Check out these figures,  
then decide for yourself!

When you  
have to go  
in the hospital...

Here's what  
Hospital Medicare  
pays...

Here's what  
Old American  
MEDICARE  
A-Plus 5  
pays...

Here's what  
you pay if you have  
MEDICARE  
A-Plus 5

When you enter the hospital and stay 1 to 60 days.	All expenses incurred for covered services** except the first \$160 (the "deductible") and the first three pints of blood.	The first \$160 plus the first three pints of blood, at up to \$35 a pint.	None of the expenses incurred for covered services.
When hospitalized for more than 60 days and less than 91 days.	All expenses incurred for covered services except for \$40 a day.	The first \$40 of your expenses for each day.	None of the expenses incurred for covered services.
When hospitalized for more than 90 days and less than 181 days.	All expenses incurred for covered services except for \$80 a day — until Medicare "lifetime reserve" of 60 days is used up.	The first \$80 of your expenses for each day — whether or not you have used up your "lifetime reserve."	None of the expense for covered services while using up your "lifetime reserve." After reserve is used up, you pay only those expenses in excess of \$80 a day.
When hospitalized for more than 180 days (or more than 90 days if your Medicare "lifetime reserve" is used up).	Nothing.	Up to \$160 a day for hospital expenses actually incurred after the 180th day.	Only those covered expenses in excess of \$160 a day.

\*This benefit period. Once Medicare eligibility and under MEDICARE A-Plus 5, a benefit period begins whenever you are hospitalized after you have not been in a hospital or skilled nursing facility for 60 or more consecutive days.

\*\*Inpatient covered services include, but is a non-covered service (2-3 beds in a room) and all other, including special diets, Operating Room Charges, Prosthetic fitting services including eyeglasses, dentures, drugs furnished by the hospital, Laboratory tests, X-ray and other radiology services. Medicare is not paid for all services and costs. Loss of appliances and equipment furnished by the hospital such as crutches, wheelchairs, prostheses, medical alert services.

**UP TO \$50,000  
IN LIFETIME  
BENEFITS!**

## Because we want you to fully understand your benefits and coverage, please read these Questions & Answers about Medicare and MEDICARE A-Plus 5



The first \$160 plus the three pints of blood.

The first \$40 of your expenses for each day.

The first \$80 of your expenses for each day, until your "lifetime reserve" is used up. Afterwards, you pay all expenses.

All expenses have to be paid by you.



- Q.** Why should I be interested in MEDICARE A-Plus 5, if I already have the Government's Medicare (Part A) which pays for hospitalization?
- A.** Because Medicare does not pay your getting hospital bill. For example, you must pay the deductible — currently \$160 — when you're first hospitalized at the beginning of a benefit period.
- Q.** Does Medicare pay the entire daily hospital cost, after the deductible?
- A.** When you're hospitalized for more than 80 days in one benefit period — which is possible if you suffer a serious accident or illness, or are in and out of the hospital frequently — you must pay \$40 a day toward your bill. And when you're hospitalized more than 90 days in one benefit period, you must pay \$80 a day.
- Q.** If I have the MEDICARE A-Plus 5 policy, will the policy together with my government Medicare Part A, pay for any and all of my hospital expenses?
- A.** Not necessarily. Medicare Part A pays for covered services only. (See list of covered services in chart on preceding page.) For example, extra charges for such services as a private room, private nurse, or personal comfort items, are not paid for by Medicare Part A or by the MEDICARE A-Plus 5 policy. You are required to pay for any non-covered services.
- Q.** You keep mentioning "benefit period". What is a benefit period?
- A.** Under Hospital Medicare regulations, and under the MEDICARE A-Plus 5 policy, a new benefit period begins whenever you are hospitalized after you have not been in a hospital or a post-hospital skilled nursing facility for 60 or more consecutive days. For example, if you are discharged from the hospital but then re-enter the hospital before 60 days are up, it's all considered as the same benefit period.
- Q.** And the more days I'm hospitalized under Medicare in each benefit period, the greater the chance that my share of the hospital bill will be increased?
- A.** Right. Look at the chart on the preceding page and you'll see what Medicare pays, and what you have to pay — unless you have Medicare supplemental insurance like MEDICARE A-Plus 5.
- Q.** According to the chart, after I use up my Medicare "lifetime reserve", Medicare pays nothing if I'm hospitalized more than 80 days in one benefit period. What is a "lifetime reserve"?
- A.** It's a total of 80 days during which time Medicare pays all expenses for covered services except for \$80 a day. You can draw upon this reserve, one or more days at a time, whenever you are hospitalized under Medicare for more than 60 days in one benefit period. But once all of the 80 days are used up, they cannot be replaced.
- Q.** So if I'm hospitalized more than 80 days in a benefit period and I've already used up my "lifetime reserve," I get nothing from Medicare?
- A.** That's right — but if you have MEDICARE A-Plus 5, it covers the first \$80 of your expenses for each day you're hospitalized from the first through the 150th day in a benefit period. And if you're hospitalized for more than 150 days in a benefit period, MEDICARE A-Plus 5 pays up to \$160 a day for hospital expenses actually incurred.
- Q.** Does MEDICARE A-Plus 5 pay for anything else?
- A.** Yes, if you require blood, MEDICARE A-Plus 5 pays for the first three pints, or up to \$24 a pint. (Hospital Medicare does not pay for the first three pints, but does pay for the rest if required.)
- Q.** It seems that every year Medicare keeps raising the deductible and the share of the daily hospital bill I must pay. What happens if Medicare raises those amounts again?
- A.** The benefits MEDICARE A-Plus 5 pays will be automatically increased accordingly! This is an important provision of the policy. Of course, the premium may also be increased if necessary — but your insurability for the new amounts is guaranteed.
- Q.** What if I'm hospitalized for a long period of time, or if I'm in and out of the hospital a lot, will I be considered out of the plan?
- A.** No. The plan is Guaranteed Renewable. Just pay your premiums on time and you can renew the policy as often as you like — unless and until a maximum of \$60,000 in MEDICARE A-Plus 5 benefits has been paid during your lifetime. And the company cannot increase your premium, unless the premium is increased for all policyholders in your state, or of the same issue age as yours, or whose policies were issued the same year as yours.
- Q.** Who is eligible for MEDICARE A-Plus 5?
- A.** Everyone who lives in a state to which the plan was mailed and in which the MEDICARE A-Plus 5 policy is approved, and who meets the Enrollment Form by the deadline date shown on it.
- Q.** Is there a waiting period?
- A.** No. You are covered immediately for hospitalization which begins after the policy effective date.
- Q.** How much does MEDICARE A-Plus 5 cost?
- A.** If you apply now, the monthly premium is \$8.50. This averages out to about \$26 a day. (Keep in mind that without MEDICARE A-Plus 5 you must pay the deductible — the first \$160 of expenses incurred for covered services when you are first hospitalized in a benefit period — and that your expenses could easily reach \$160 for just a one or two day stay.)
- Q.** How do I apply?
- A.** Simply fill out the Enrollment Form enclosed, and mail it in before the deadline shown. There is no physical examination required. And you may use the Same Form to enroll your spouse, too. The additional premium is the same as yours.

Act now—complete and return your MEDICARE A-Plus 5 Enrollment Form before the deadline date shown!

**Here's how to establish your lifetime eligibility for supplementary Hospital Medicare coverage that helps pay the share of covered hospital expenses that Medicare leaves to you!**

1. You must be the individual designated on the enclosed, non-transferable Certificate.
2. You must be a resident of the state to which this mailing is addressed.
3. You must mail your Enrollment Form no later than the deadline date shown.

(Issue of this policy is guaranteed ... but only to those who meet all 3 requirements.)

Dear Friend:

As you may know, you do not need to apply for the Government's Medicare Part A--the hospital part of Medicare. Most Americans 65 and over--provided they are eligible for Social Security--receive it automatically.

But ... as many persons who are covered by Medicare have found out, going to the hospital can still be costly. The government's program, you see, has deductibles and coinsurance limitations which require you to pay part of your hospital expenses--and these can add up to a sizable amount!

This is why Old American Insurance Company has developed a Medicare Supplement insurance plan. Called MEDICARE A-Plus 5, our plan pays the deductible and coinsurance amounts you would otherwise have to pay ... and even helps pay hospital costs in those extended stays when Medicare pays nothing!

This is the kind of sensible, realistic financial protection every American 65 or over should have. However, not everyone is automatically eligible for it. You must apply, and meet the three requirements outlined above, in order to be accepted.

If you do meet those requirements, your acceptance is guaranteed, regardless of your health or the number of times you have been hospitalized in the past!

If you qualify, then all this valuable protection is yours with MEDICARE A-Plus 5

PLUS #1 -- Pays the deductible and coinsurance amounts that you must pay when hospitalized under Medicare. Any hospital confinement beginning after the policy effective date is covered.

(Over, please)

- PLUS #2 -- Even helps pay hospital costs (up to \$160 a day) in those extended stays when Medicare pays nothing—to give you valuable protection against long or frequent hospital stays!
- PLUS #3 -- Automatically adjusts to pay the current Medicare deductible and coinsurance amounts, whenever they increase (as they have each year for the past nine years). Of course, the premium may also be increased if necessary—but your insurability for the new amounts is guaranteed.
- PLUS #4 -- Guarantees you the option to obtain additional benefits when offered—regardless of your physical condition at the time.
- PLUS #5 -- Guarantees to issue you the policy, regardless of your present health condition ... and guarantees to renew your policy, for as long as you wish, unless and until you have received the maximum total lifetime benefits of \$50,000! And the company cannot increase your premium, unless it's increased for all policyholders in your state.

When you consider that MEDICARE A-Plus 5 costs \$9.50 a month, it's easy to see that even a full year's protection costs less than the Medicare deductible of \$160 that you would have to pay out of pocket even if you were in the hospital for just one or two days! Also, when you consider the fact that one out of three persons ages 65 and older will be hospitalized this year,\* it just makes good sense to have this kind of protection. (\*Social Security Administration Current Medicare Survey.)

Let me repeat ... if you meet the three requirements outlined at the beginning of this letter, you cannot be turned down—regardless of your physical condition and regardless of how many times you may have been hospitalized in the past. No medical examination is required, and there is no lengthy medical questionnaire to fill out.

All we require is that you fill in and mail the enclosed Reservation Certificate before the deadline date. IMPORTANT: Regardless of your decision, it is essential that we have your "Yes" or "No" answer so our records may show that you have been offered this opportunity, and either accepted it or waived your eligibility during this current enrollment period.

When you receive your MEDICARE A-Plus 5 policy, read it over. You'll see all the benefits and guarantees I stated in this letter. Then if you are not 100% satisfied, simply return it within 10 days and owe nothing. Your first month's premium will be refunded in full, no questions asked.

Fair enough? If you agree, then I urge you to send for your policy at once. Your policy (Series ID3044 or ID3050) will be in force from its effective date just as soon as it is issued at the company's home office. Why not take time right now to check the "yes" box, then fill in the Enrollment Form and mail your Certificate in the enclosed envelope. Send for your MEDICARE A-Plus 5 policy today!

Sincerely,

*Joseph J. McGee, Jr.*

Joseph J. McGee, Jr.  
President

P.S. If your spouse wishes to enroll, too, add his or her name on the Enrollment Form. The additional premium is the same as yours.

**EXCLUSIONS:** The policy does not cover confinement in a nursing home, convalescent home, extended care facility or institutions for the care of the mentally ill, drug addicts, tuberculars or alcoholics.

**OLD  
AMERICAN  
INSURANCE  
COMPANY**

4900 OAK STREET • KANSAS CITY, MISSOURI 64111

**IF YOU HAVE ALREADY DECIDED  
not to enroll in MEDICARE A-Plus 5,  
do yourself a favor and look at  
some statistics—you may wish  
to change your mind!**

Dear Friend:

Here's a statistical fact that's not particularly cheerful, but it's one to be reckoned with: this year about one out of three persons age 65 and over will be hospitalized. This is twice the admission rate for ages 35-54!\*

Another statistic worth noting: some 12 million persons age 65 and over, more than half the total population in this age group, now hold private health insurance policies to supplement benefits received under Medicare.\*\*

(Over, please)

\*Dept. of Health, Education and Welfare, Publication No. 73-3004

\*\*Health Insurance Institute, 1977-78 Source Book

Why do so many people buy hospital insurance to supplement their Medicare coverage? The reason is simple. They know that Medicare does not cover all hospital expenses ... and that they must pay part of the costs.

Even those persons who continue working beyond age 65 still are eligible for Medicare and therefore need supplemental coverage.

The percentage of Medicare costs the patient has to pay has been increasing. In 1970, 19% of the costs of Medicare hospitalization was borne by the patient. In 1974, the Medicare-covered patient paid, on the average, 25% of the hospitalization cost.\*\*\* And since then the percentage has further increased as the deductible and coinsurance amounts have increased each year.

Well, so much for statistics. Maybe at this point you're saying to yourself ... "But I'm living on a fixed income. What with inflation and all, I just can't afford to put out the money for hospitalization insurance, even though I know I need it."

If that's your feeling, may I suggest you look at it this way--can you afford not to have this protection? Here's a little arithmetic which may answer this question for you: MEDICARE A-Plus 5 costs \$9.50 a month, \$27.70 every three months, \$55.00 every six months or \$109.20 a year, depending on the payment plan you choose. Yet, if you have to go to the hospital just once this year ... and stay only a day or two ... your expenses could easily reach \$160. Under Medicare, you have to pay the first \$160 of expenses when you're first hospitalized in a benefit period. But if you have MEDICARE A-Plus 5, this \$160 is paid for you. So, you would get back more than you paid in in a year's time.

\*\*\*Social Security Administration Current Medicare Survey

But the really important thing to keep in mind is this: Should you be hospitalized for more than 60 days in a benefit period, under Medicare you will have to pay the first \$40 a day of expenses for covered services --\$280 a week! If you have MEDICARE A-Plus 5, this \$40 a day will be paid for you from the 60th to the 90th day of hospitalization.

Of course, the average hospital stay is nowhere near 60 days. But who can say how long your stay will be should you be hospitalized? MEDICARE A-Plus 5 helps give you financial protection, too, against an extra long hospital stay! (Complete details on the MEDICARE A-Plus 5 policy are outlined in the accompanying letter.)

I hope I haven't strained your patience with this extra letter, but I just felt you should be aware of these health care statistics. Because, these days you have to depend largely on yourself for protection against rising costs, especially in the area of health care. And the more information you have, the better you'll be able to make a decision as to what's right for you.

So I urge you to provide yourself with some form of hospital insurance to supplement your Medicare coverage. I hope you'll choose MEDICARE A-Plus 5. But, whichever plan you choose, don't delay. For we just never know when we will become part of the hospitalization statistics.

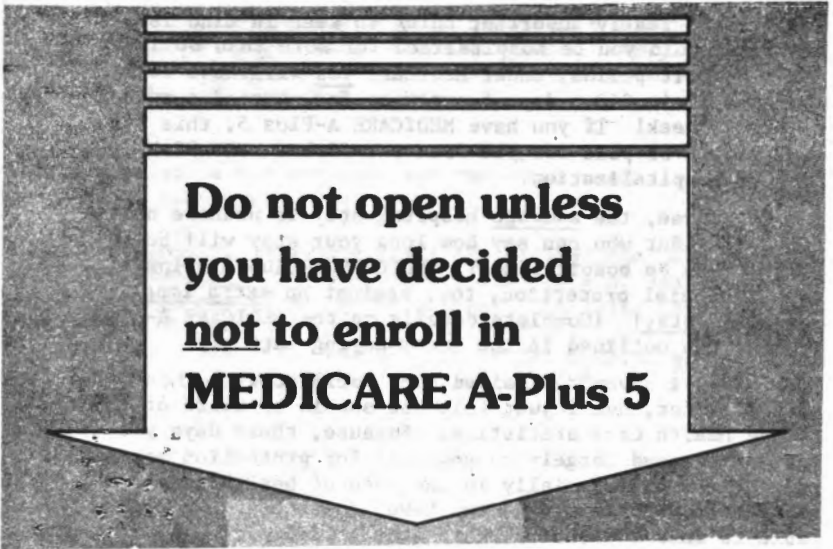
Sincerely,

*Joseph J. McGee, Jr.*

Joseph J. McGee, Jr.  
President

JM:dp  
Enc:L982

P.S. Remember, your satisfaction is guaranteed. If you decide not to keep the policy just return it within 10 days and we'll refund your premium in full - no questions asked!



## APPENDIX VI

**Examples of advertising material used by Loyal American Life Insurance Co. in conjunction with sales of cancer insurance through credit unions.**



**T**ransportation  
FEDERAL CREDIT UNION

POST OFFICE BOX 23815  
WASHINGTON, D. C. 20024

PHONE: 426-8475  
CHARTER NO. 3140

Dear Credit Union Member,

For those members who are not yet participating in the High-Limit Cancer Expense Protection Plan, we've arranged for you to have an enrollment opportunity.

We know cancer can generate expenses much greater than ordinary health insurance was designed to cover. And since the American Cancer Society says cancer will eventually strike 2 out of every 3 families, you see why protecting yourself financially is so important.

This plan provides the same protection for you and each insured family member. Plus, it pays full benefits in addition to any other plan of insurance you have, including group and Medicare. The benefits, cost and conditions of coverage are fully explained in the brochure.

To apply, simply fill out the short application form and return it, with your check or money order for the appropriate annual premium, in the postage-free envelope. Coverage will begin on the date your application is accepted by Loyal American Life Insurance Company.

Thousands of credit union members are already protected. Take a tip from them and consider what this important protection could mean to you. Please do it today! If you've already signed up for cancer protection through the credit union, don't re-apply. Let this remind you of the wise decision you made in protecting yourself against the financial burden of cancer.

Sincerely,

*William G. Derry*  
William G. Derry  
General Manager

P.S. For this enrollment, the benefit waiting period is waived. So enroll before the date shown on the application.

A special representative will be in credit union office on Wednesday, September 26th 1979 from 11:00 a.m. to 3:00 p.m. to assist you in enrolling and answer any questions you may have.

# THE FAMILY CANCER PROTECTION PLAN

\$ 50,000  
MAXIMUM AVAILABLE  
ON EACH  
FAMILY MEMBER



**HOSPITAL CONFINEMENT BENEFIT**

Pays \$50.00 per day for the first seven days, and \$30.00 per day for each day thereafter. If less than 30 days separates two periods of hospital confinement the two periods of confinement shall be considered as one and payment for second period made at \$30.00 per day.

**DRUGS AND MEDICINES**

Actual charges by hospital for drugs and medicine while confined, but not to exceed 20% of the hospital confinement benefit for each claim.

**BLOOD AND PLASMA (limit \$300.00)**

Usual and customary charge for blood and plasma. No limit for leukemia.

**SURGICAL**

\$50.00 to \$500.00 per operation as outlined in Schedule of Operations. Hospital or Doctor's office.

**ATTENDING PHYSICIAN (limit \$600.00)**

Pays actual charge for one visit per day, made by attending physician (other than the surgeon) not to exceed \$10.00 per day while the insured is confined in hospital.

**ANESTHESIA**

Actual charges not to exceed \$70.00 per operation. Fee limited to \$30.00 for skin cancer operations.

**X-RAY RADIUM AND COBALT THERAPY**

(limit \$1,000.00)

Actual charges for X-Ray Radium and Cobalt therapy; excluding diagnostic X-Ray in or out of hospital.

**NURSING (limit \$600.00)**

Up to \$24.00 daily, while confined to hospital; for registered graduate nurse, or licensed practical nurse as required.

**AMBULANCE BENEFIT (limit \$500.00)**

Usual charges made for transportation by ambulance to and from hospital in which the insured is admitted as a patient, not to exceed \$50.00 for each confinement.

**EXTENDED BENEFITS**

If you choose the regular benefits, your policy's "extended benefits" clause will pay 100% of all customary hospital charges after 90 days of continuous, uninterrupted hospitalization up to \$5,000 a month, without any deduction for prior benefits paid.

**The amounts above are the maximum payable over each insured's lifetime — Total of all benefits paid shall not exceed \$50,000.00 each on every insured family member.**

### **The Disability (Hospital Indemnity) Option**

Your cancer insurance has a disability (hospital indemnity) option that pays you \$70.00 (seventy) a day for the first 30 days of hospital confinement, \$50.00 (fifty) a day for the next 60 days of confinement, and \$35.00 (thirty-five) a day after 90 days of hospital confinement, not to exceed \$50,000.00 total on each insured (after three months of hospital confinement, \$300.00 per month for confinement in a nursing home, except for skin cancer).

## **SOME STRAIGHT TALK ABOUT LOYAL AMERICAN'S FAMILY CANCER PROTECTION PLAN AND WHAT IT CAN DO FOR YOU.**

### **Q. Why do people need cancer coverage?**

**A.** According to the American Cancer Society, one million Americans will receive medical treatment for cancer this year. Cancer will strike two out of three American families at some time, and one out of every four Americans, or 53 million people will suffer some form of cancer. Even worse, the staggering cost of cancer treatment can bankrupt the average family. In a time of need, the Loyal American Cancer Protection Plan can help make up the difference.

### **Q. Who will receive the benefits?**

**A.** These benefits are paid directly to you, or to whomever you say.

### **Q. Can Loyal American cancel this insurance?**

**A.** Not as long as you pay your premiums on time.

### **Q. Are there any exclusions, limitations or reductions?**

**A.** Yes! (1) We can't insure anybody who has ever had cancer, been diagnosed with cancer, or told that a cancer condition may exist.

(2) There is a 90 day waiting period after your policy is issued before any benefits will be paid.

(3) Cancer must be positively diagnosed from microscopic examination of fixed tissue by qualified pathologist. (4) Cancer operations not listed in policy schedule are paid according to generally accepted relative value studies.

### **Q. If I have any other insurance, will my cancer insurance still pay?**

**A.** Yes! The policy pays regardless of any other medical insurance you may have with another company, including Workmen's Compensation and Medicare.

**Q. Can I still keep my protection if I leave the Credit Union?**

**A. Yes!** This is your personal policy. Should you ever leave the Credit Union, you can pay your premiums directly to Loyal American Life Insurance Company on an annual basis.

**Q. Does a family policy cover the whole family?**

**A. It covers you as primary insured, your spouse, and all unmarried dependent children under 25 years of age living in the same household with the primary insured or attending an accredited school full time.**

**Q. Can I apply regardless of my age?**

**A. Yes!** Our cancer protection plan has absolutely no age limit.

**Q. Will my policy pay for any other sickness or disease?**

**A. No!** It pays only for definitive treatment of cancer.

**Q. How do I file a claim?**

**A. 1. Complete the claimant statement. 2. Enclose the hospital statement. 3. Enclose all pathology reports on each hospitalization. 4. And, furnish any additional eligible charges. 5. Then, mail all of the above directly to Loyal American.**

**Q. How do I get my Cancer Protection Policy?**

**A. Send no money.** Fill out the short application form and simply authorize your Credit Union to deduct \$10.00 every three months from your share account for family coverage, or \$7.00 for single coverage, that simple. After you receive your policy, look it over. Should you find it a friend or financial advisor. If, for any reason, you're not satisfied simply return your policy within 30 days for a complete refund of premium and we'll cancel the policy.

Act now! 11 1/2 cents a day is precious little to pay to protect your life, your loved ones, and your life savings.

**KNOW CANCER'S WARNING SIGNALS!**

1. Thickening or lump in breast or elsewhere
2. Indigestion or difficulty in swallowing
3. Change in bowel or bladder habits
4. Obvious change in wart or mole
5. Unusual bleeding or discharge
6. Nagging cough or hoarseness
7. A sore that does not heal

If you recognize a warning signal, see your Doctor.

**THIS IS A CANCER ONLY POLICY FORMS #L-742; L-743; L-1043 DC; L-811 (SC); L-819 (GA); L-998 (TEX); L-756 (ARK); L-743 (MINN).**

**L - 1129**

93 7697

# LOYAL AMERICAN CANCER PLAN LIMITED APPLICATION FORM

Midnight Monday  
October 15, 1979

Policy Number \_\_\_\_\_

CUCP **80-009** \_\_\_\_\_

**TRANSPORTATION FEDERAL CREDIT UNION**  
OFFICIAL CREDIT UNION NAME

**You Must Reply By**

PRIMARY  
INSURED'S  
NAME

\_\_\_\_\_  
(please print) Last First Middle Initial

Billing Code

Male

SEX

Female

DATE OF BIRTH

ADDRESS \_\_\_\_\_

Street

City

State

Zip Code

Month Day Year

Have you or any of the other Proposed Insureds ever been treated for, diagnosed as having, or been told by your doctor that you may have cancer?  YES  NO

If YES, give the name or names of the individuals who have been treated, diagnosed or told cancer may exist: 

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

NUMBER ELIGIBLE DEPENDENTS	FIRST PREMIUM (Place "X" in Proper Box)	Have you been a member of the Credit Union 31 days? <input type="checkbox"/> YES <input type="checkbox"/> NO	RENEWAL PREMIUM Each renewal shall be at the established standard premium rate for this plan on the date of each renewal.	COMPANY USE ONLY Date of Issue  (Same as Effective Date)
	ANNUAL \$28.00 <input type="checkbox"/>			
x _____	Primary insured & Family \$40.00 <input type="checkbox"/>			

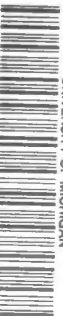
I hereby represent that the foregoing answers are made by me and are true and complete to the best of my knowledge. This plan of insurance was selected by me on my own initiative and I further understand that I may select any other insurer of my own choice. Subject to the above and all other terms of the policy hereby applied for, I understand that insurance shall become effective on the date of issue; that any individual named above who has been treated for, diagnosed as having, or been told by his doctor that he may have cancer, is excluded from coverage and the policy will pay benefits only on any proposed insured who for the very first time in the entire lifetime of said individual is treated for, or diagnosed as having cancer on, or after, the 90th day following the date of issue.

(Place Date Here)

\_\_\_\_\_  
L-991 Licensed Resident Agent  Soliciting Agent  x (Sign Here) \_\_\_\_\_ Primary Insured's Signature—Do Not Print  Date Signed

Loyal American Life Insurance Co., Mobile, Ala.

3 9015 03173 4281



UNIVERSITY OF MICHIGAN

2992