DECEPTIVE OR MISLEADING METHODS IN HEALTH INSURANCE SALES

HEARING

BEFORE THE

SUBCOMMITTEE ON FRAUDS AND MISREPRESENTATIONS AFFECTING THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

EIGHTY-EIGHTH CONGRESS

SECOND SESSION

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CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

STATEMENTS

ADDITIONAL INFORMATION

DECEPTIVE OR MISLEADING METHODS IN HEALTH INSURANCE SALES

MONDAY, MAY 4, 1964

U.S. SENATE,
SUBCOMMITTEE ON FRAUDS AND MISREPRESENTATIONS
AFFECTING THE ELDERLY OF THE
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met at 10 a.m., in room 4232, New Senate Office Building, Senator Williams (chairman of the subcommittee) presiding.

Present: Senators Williams, Keating, and Fong.

Staff: William E. Oriol, professional staff member; Patricia Slinkard, chief clerk; and Mary Keeley, staff assistant.

Senator WILLIAMS. The subcommittee will come to order.

I would like to start this morning's inquiry with a short opening statement.

Once again this subcommittee meets to learn more about frauds and misrepresentations affecting the elderly. Today we are interested in deceptive or misleading methods used to promote health insurance sales or localized "health plans."

One of the reasons for our interest is that we have received many letters from individuals who are sometimes hopelessly confused about the policies they once purchased for protection in retirement years. Quite often they tell us that the policies have, for one reason or another, failed them when they most needed help.

Staff subcommittee inquiries have intensified our interest, as have consultations with State and Federal agencies.

Today's testimony will give us a better idea of the magnitude of the problem and will help determine whether additional inquiry by this or other subcommittees is required.

Two points should be emphasized:

This subcommittee recognizes that the majority of mail-order firms and other health insurance companies are honestly interested in giving value to their customers. It is for the protection of those reputable companies, as well as for the benefit of the buying public, that this subcommittee is conducting this hearing.

The second point is that many of the practices we will hear about today do not fit neatly into the standard definitions of "fraud" or "deception." The subcommittee recognizes that the language of the law may not meet all situations, particularly when slippery pitchmen deliberately set out to find gaps in that language. It may well be that our statutory definitions of fraud and deception should be modernized.

One thing is certain, however: that the sale of an insurance policy is too serious a matter to become a battle of wits between buyer and seller.

Buyers can be misled as much by the omission of facts as by the deliberate distortion of facts; and buyers can be presented with so many facts that truths become lost. And quite often, too, the buyer unwittingly can put himself in a position where he has only limited recourse if his claim is disputed.

In any case, the final result is the same. The buyer discovers—usually when the time comes to pay a hospital bill—that he does not have the protection he paid for and thought he had.

One of the responsibilities of this committee is to consider such problems and to increase public awareness of them. Our State and Federal witnesses will also help us to consider whether tightening of present authority is required.

Our hearing follows 3 days of hearings conducted by Senator Pat McNamara, Michigan, chairman of the Subcommittee on Health of this Special Committee on Aging.

Witnesses testified on cost, coverage, and adequacy of private health insurance and Blue Cross policies. The interests of the two subcommittees overlap, and I wish to extend my appreciation to Senator McNamara for inviting me to participate at the hearing of his subcommittee last week.

I would also like to say that staff members of the two subcommittees have consulted at some length on matters of mutual interest.

Senator Dodd, who heads the continuing study into the insurance industry for Senator Hart's Subcommittee on Antitrust and Monopoly, of the Senate Judiciary Committee, would have liked to be here attending this hearing today but other Senate business kept him away. Dean Sharp, a staff representative of that subcommittee, I understand, is here with us as an observer.

I will close by noting that an invitation to testify was extended to the Health Insurance Association of America. This organization has also been informed that the hearing record will remain open for 2 weeks after this date for any statement it may wish to make. I believe a representative of that organization is here today.

A similar invitation was extended to the Association of Insurance Advertisers. We have been informed that this organization will submit a statement for our record.

We work with the early morning hazard or reality of having to stop hearings during quorum calls and, at 6 minutes after 10, we are always faced with a quorum call. I can walk 100 yards in 5 minutes; maybe we can improve on that record.

I will return.

(Recess.)

Senator WILLIAMS. We will come to order, again.

We have as our first witness, Mr. James Henderson, General Counsel of the Federal Trade Commission.

We are glad to welcome you before this committee this morning, Mr. Henderson. We look forward to your statement.

Mr. HENDERSON. Thank you, sir. Again I would like to introduce my associates to the committee: Mr. John Lexcen, my assistant; Mr.

James Murray, Assistant Director of the Bureau of Deceptive Practices; Robert Beller, attorney in our Bureau of Industry Guidance; and Fletcher Cohn, Assistant General Counsel for Legislation.

Senator WILLIAMS. All right, Mr. Henderson.

STATEMENT OF JAMES McI. HENDERSON, GENERAL COUNSEL, FEDERAL TRADE COMMISSION; ACCOMPANIED BY JOHN LEXCEN, ASSISTANT TO THE GENERAL COUNSEL; JAMES MURRAY, ASSISTANT DIRECTOR, BUREAU OF DECEPTIVE PRACTICES; ROBERT BELLER, ATTORNEY, BUREAU OF INDUSTRY GUIDANCE; FLETCHER COHN, ASSISTANT GENERAL COUNSEL FOR LEGISLATION

Mr. HENDERSON. Mr. Chairman, your invitation to the Federal Trade Commission to present its views on mail-order insurance is particularly welcome at this time. The Commission in the past week has adopted guides for the mail-order insurance industry. The guides will be promulgated to the public and industry shortly. I was informed they will be available about the 15th of May. It is purely a printing job that remains to be done.

These guides will furnish a standard against which insurance advertising and mail-order insurance claims may be measured and judged by the public.

The guides have no probative effect but are intended to clarify for the mail-order insurance industry the laws on deception which may apply to their practices. Insurance companies which heretofore may have preyed upon the needs of the elderly for adequate insurance protection will be given an opportunity to comply with the law. Thereafter, if the companies are within the jurisdiction of the Federal Trade Commission—those companies engaged in the sale of insurance in commerce by means of the mails in any State in which they are not licensed to conduct the business of insurance, or in which, though licensed, they do not have any agents—appropriate mandatory proceedings may be commenced to compel them to cease and desist from unlawful conduct such as deception in advertising.

In discussing these matters before the committee, I must state that the views I express are not necessarily those of the Commissioners or the Commission. However, within that limitation, it is hoped the testimony will be of use to the committee in its deliberations.

The Federal Trade Commission Act, in section 5, authorizes the Commission to proceed against unfair or deceptive acts and practices in commerce. Guide 1 of these mail-order guides states the law on general deception:

> No advertisement shall be used which because of words, phrases, statements, or illustrations therein or information omitted therefrom has the capacity and tendency to mislead or deceive purchasers or prospective purchasers, irrespective of whether a policy advertised is made available to an insured prior to the consummation of the sale, or an offer is made of a premium refund if a purchaser is not satisfied. Words or phrases which are misleading or deceptive because the meaning thereof is not clear, or is clear only to persons familiar with insurance terminology, shall not be used.

The committee's attention is first directed to the matter of general deception. The guide makes it plain that if a company's advertising deceives because of an affirmative statement, or because it omits a statement which should be made, or if the advertising has a capacity and tendency to deceive, then no subsequent retraction or refund of premium will cure the unlawful nature of the deception.

This provision accords with what has been found characteristic in many areas of the trade. An advertisement, deceptive in nature, is used to attract a customer. Before the sale is closed, a bible print contract is exhibited which states the true nature of the insurance. The customer, hurriedly reading the small print, sees what he has been told he should see, and misinterprets or fails to grasp the truth. Refunding a premium thereafter is not a satisfactory means of redressing the original wrong. When the misrepresentation is discovered, a period of time has passed during which the customer is without insurance. A refund of premium when a claim for benefits has been made is even more hurtful since expenses may have been incurred in reliance on that policy.

The guide on general deception also takes note of the specialized vocabulary which when used in the sale of insurance to an unknowledgeable purchaser may substantially mislead him. Although the language may be technically correct in insurance circles, it may be deceptive or lacking in clarity to the layman. Consequently, its use is not permitted; nor should its specialized accuracy be a defense to a charge of deception.

Certain specific deceptions may occur in the advertising and sale of mail-order insurance. Each of them is related to the general deception in the manner of its operation, that is, misstatement, by concealment, by specialized language which may mislead, or by a statement of the truth in such a manner as to give a false impression. Here are some of the means of deception:

An advertisement which fails to disclose:

1. Exceptions, reductions, or limitations of the policy;
2. A waiting, elimination, probationary, or similar period before the policy becomes effective and benefits become payable;
3. That benefits are payable only on the occurrence of certain conditions, and what those conditions are;
4. The effect preexisting conditions of health may have on insurance coverage;
5. The age limitations within the policy when the policy is applicable only to a certain age group;
6. All terms affecting renewability, cancelability, or termination, or which directly misrepresent such matters:
7. That a combination of policies is involved when the advertisement refers to various benefits which are contained in more than one policy;
8. That total benefits are allocable among family members and not payable in total on the death of one member, when such is the fact.

An advertisement which represents:

9. That the health of the insured is not a factor affecting insurability or payment of benefits, when such is not the fact;
10. That no medical examination is required when medical examination before payment of benefits is or may be required;

11. Truthfully, that no medical examination is required when there is no disclosure of the limitations which the insurer places on his liability under the policy so issued;

12. Testimonials, appraisals, or analyses of policies which are not genuine, or do not represent the current opinions of the author, or an advertisement which does not accurately describe the facts or reflect the current practice of the insurer;

13. Statistics such as time within which claims are paid, dollar amounts paid, number of claims paid or persons insured under a particular policy, or other statistics, which do not accurately reflect all the relevant facts on which the statistics are based;

14. That claim settlements are liberal or generous beyond the terms of the policy.

An advertisement which:

15. Uses words which indicate broader coverage than the policy affords;

16. Uses words which imply greater benefits than the policy affords, such as "up to" and "as high as" when perhaps only one benefit is equal to the maximum figure;

17. Implies that the policy provides additional benefits for certain illnesses, when such is not a fact;

18. Misleads or may mislead purchasers concerning the insurer's assets, financial ability, relative position in the insurance industry, or any other material fact.

It is not intended that the committee should believe the foregoing list is a complete catalog of the deceptions which are, or may be, currently used in unscrupulous insurance advertising and mail-order insurance. However, the list is indicative of the type which may be used. Other misrepresentations, if they fail to meet the standards of the Guide on General Deception, are likewise violations of the Federal Trade Commission Act.

There are specific guides adopted by the Commission which pertain to problems frequently encountered by the elderly in their purchase of insurance. Guide 2(a) (3), referring to preexisting conditions, states:

> If a policy provides any limitations on the coverage of a loss if the cause of such loss is traceable to a condition existing prior to the effective date of the policy, or prior to any other particular time, any reference to the policy coverage of the loss made in any advertisement must be closely accompanied by clear and conspicuous disclosure of such limitations. (See also guide 3.)

Guide 3, referring to health of the applicant or insured, states:

> No advertisement shall be used which represents or implies—
>
> (1) That the condition of the applicant's or insured's health prior to, or at the time of the issuance of a policy, or thereafter, will not be considered by the insurer in determining its liability or benefits to be furnished for or in settlement of a claim when such is not the fact (see also pt. A (3) of guide 2); or
>
> (2) That no medical examination is required if the furnishing of benefits by an insurer under a policy so represented is or may be contingent on a medical examination under any condition; or
>
> (3) That no medical examination is required, even though such is the case, without conspicuously disclosing in close conjunction therewith all the conditions pertaining to or involving the insured's health under which the insurer is not liable for the furnishing of benefits under a policy.

It is apparent from the statement of these sections of the guides that their purpose is to eliminate the "insurance regardless of health"

misrepresentation. Actually, of course, there is seldom an intent by the predatory company to issue a policy which really provides benefits of "insurance regardless of health." The careful hedging of the policy provisions in many cases denies liability or limits liability for preexisting conditions. Elderly people, by the fact of their age, have preexisting conditions of health which may disqualify them from full coverage, or any coverage, by policies which they purchase, without actual knowledge of their conditions.

As a fortification of the belief that the policy will provide benefits regardless of the insured's health, advertisements have offered insurance which will be written without a medical examination. However, in the provisions of the policy, a predatory company will insert a requirement that a medical examination is necessary before a claim for benefits will be paid, or that no indemnity will be paid for disability if the cause is traceable to a condition existing prior to 30 days after the policy issues.

These deceits are to my mind most grievous violations of law and morals, since they deprive the elderly and infirm of the very protection for which they pay.

Another category of problem which aging persons encounter is the provision for age limitation in the policy sometimes coupled with a provision governing renewability, cancellation, or termination. Guide 2A (5), referring to age limitation, states:

> Any reference in an advertisement to any insurance coverage or benefits which by the terms of the policy are limited to a certain age group must be closely accompanied by clear and conspicuous disclosure of such fact.

Guide 4, referring to renewability, cancellation, or termination, states:

> (a) No advertisement shall refer, directly or by implication, to renewability, cancelability, or termination of a policy or a policy benefit, or contain any statement or illustration of time or age in connection with any benefit payable, loss, eligibility of applicants, or continuation of a policy, unless in close conjunction with such reference, statement or illustration there is clear and conspicuous disclosure of the material provisions in the policy relating thereto.
>
> (b) No advertisement shall represent or imply that an insurance policy may be continued in effect indefinitely or for any period of time, when, in fact, said policy provides that it may not be renewed or may be canceled by the insurer, or terminated under any circumstances over which the insured has no control, during the period of time represented.

Obviously the misrepresentations these guides are intended to correct are addressed to persons advancing in age and suffering a gradual loss of insurability by reason of advancing age. It is certainly a minimal requirement that insurance which by its printed terms does not include persons over a stated age should be advertised with a limitation noted.

Equally important, and with a capacity for great harm, are the advertisements of insurance which mention renewability but fail to disclose that the company may, in its discretion and for reasons beyond the control of the insured, fail to renew the insurance, or directly cancel or terminate its applicability. This deception has the tendency to cause a purchase of insurance in the belief that it will be continued while the premium is paid. At a time for the elderly when insurance is difficult to obtain and the benefits of the purchased policy are most necessary, an unexpected cancellation by the company causes hardship and heartbreak for the insured and his family.

Here again, to my mind, the practice is immoral as well as unlawful.

The Federal Trade Commission by its adoption of these guides intends to furnish to the industry and to the public a measure for the truthful advertising of mail-order insurance. The Commission has sought and obtained the cooperation of the National Association of Insurance Commissioners to assist in preparation of the guides, and they have been very helpful to us.

It would be less than candid to overstate to the committee the limits of the Commission's jurisdiction in insurance matters. The Commission to a great extent relies upon the aid of the National Association of Insurance Commissioners and the cooperation of State authorities for adequate regulation of mail-order insurance advertising.

This reliance is important not only because it is good Government, but the McCarran-Ferguson Act of 1945, as amended in 1947, makes the business of insurance subject to the provisions of the Federal Trade Commission Act, and other antitrust acts to the extent such business is not subject to State regulation. Cases involving the limits of our jurisdiction have in a practical sense marked out the area of mail-order insurance. The Commission is able to act when the State into which a mail-order solicitation is sent has not licensed the soliciting company, and no agent of the company for the service of process and property on which judgment can be executed may be found within the State. This is the case of *Travelers Health Association* v. *F.T.C.*, on remand at 298 F. 2d 820, 824. The test is whether the State is able in fact, to regulate the insurance business of the company.

Therefore, in a real sense, the guides must be self-enforcing. It is possible to give the industry and the public the information needed to halt predatory practices in mail-order insurance. But it is the intent of Congress, as expressed in the Insurance Act of 1945, that the Federal Trade Commission exercise its powers in a limited area.

The Commission cooperates with the State insurance commissioners in the area of insurance advertising and we compliment them for their efforts to reduce the number and kind of deceptions which affect the sale of mail-order insurance within their respective States. It commends the efforts of many responsible insurance executives who seek the correction of these practices within the industry.

It is respectfully urged that the Congress continue its interest in the problems of the elderly, and the Commission offers to do, within its jurisdiction, everything that it may to maintain the economic stability and the dignity of this Nation's aging citizens.

Attached to the statement are illustrative examples of deceptive claims in mail-order insurance advertising, and a list of those insurance cases in which the Commission has entered orders to cease and desist.

That completes my statement, Mr. Chairman.

Senator WILLIAMS. Thank you very much, Mr. Henderson.

We will include in the record the appendix material of cases that you just mentioned. I am sure they will be very helpful to give us the practical effect of your authority and how you exercise it within the guides of law and regulation that you describe.

(The material referred to above follows:)

(Text continues on p. 16.)

ADDENDUM

The material hereinafter set forth is a summary of the allegations of complaints issued as a result of the investigation of 1954. The advertising claims then made in connection with the sale of hospitalization, health, and accident insurance are approximately the same as those in current use.

This summary is presented to the committee for illustration only.

1. *Misrepresentation of policy termination provisions.*—Typical claims are these:

"No automatic termination age, no increased costs, or reduced benefits after policy is issued.

"You and your family are covered from 1 to 75."

Actually, most of the policies sold in this field are renewable solely at the option of the company. Each new premium purchases insurance for a new term. The majority of these policies can be canceled by the company at the end of any term for any reason. This is done by refusing to accept the premium payment. The complaints challenge advertisements which falsely represent or imply that a cancelable policy will remain in effect as long as the insured pays his premiums.

2. *Misrepresentation of extent of coverage.*—The complaints challenge advertising claims which state that benefits will be paid in cases of accident or sickness generally. A typical claim is:

"It pays you up to $15 a day for 100 hospital days—for each sickness or accident."

There are in fact many cases of accident or sickness for which policies so represented do not provide payment. For example, many policies will not pay at all for losses due to certain causes such as nervous disorders, dental operations, venereal disease, pregnancy, childbirth, miscarriage, etc.; they will not pay for losses due to other causes such as hernia, tuberculosis, heart disease, appendicitis, etc., unless originating at least 6 months after the policy date; and they will not pay for any loss due to sickness which can be traceable to conditions existing prior to the date of the policy.

3. *Misrepresentation of maximum dollar limits.*—Many of the companies state that claims up to a specified amount will be payable for certain medical, hospital and surgical services. For example:

"We pay up to $525 for each surgical operation.

"Surgical fees, up to $400."

These claims imply that if a person has a surgical operation, he will receive up to the amount specified, depending on the cost of the operation. Actually, many policies provide that the full amount is payable only for one or two comparatively rare operations. The maximum amount payable for the average operation is one-fourth of the specified amount, or even less.

4. *Misrepresentation of the beginning time of coverage.*—Certain companies represent that the coverage is effective at the date of issuance when actually, coverage for many sicknesses is delayed until the policy has been in effect for a specified period of time—for example, 6 months in cases of tuberculosis or heart disease.

5. *Misrepresentation concerning health status of applicant.*—Certain companies state that no medical examination is required to obtain their policies. This implies full coverage without regard to the general health of the applicant when the policy is issued. What the advertisements do not disclose is that the policy does not cover any loss traceable to a condition in existence at the time the policy was issued.

6. *Misrepresentation relating to sale of a plan.*—Representations of some of the companies imply that a great number of benefits can be obtained from the purchase of one policy for a few cents a day when actually several policies must be purchased at a higher cost to obtain all the listed benefits.

7. *Misrepresentation of benefits as payable for life.*—Some of the companies have made representations which imply that a specified income will be paid as long as the insured is disabled, even if for life. For example:

"It pays you a regular monthly income up to $200 when disabled by accident or sickness—even for life."

As a matter of fact, such payments are payable for a limited period of time in cases of disability due to sickness or cases of partial disability due to accident. Only in cases of absolute total disability due solely to accidental bodily injury are the payments made as represented.

1. MISREPRESENTATION OF POLICY TERMINATION PROVISIONS

The claim

"No automatic termination age—total disability for accident or confining sickness is paid at the rate of one-half the regular monthly benefit for life if incurred after age 60."

"No reduction in benefits because of age."

"Benefits do not decrease at any age."

The facts

"The indemnification provided * * * against loss may not be continued indefinitely at the option of the insured.

"The indemnification provided * * * is subject to cancellation by the respondent, and the insured * * * is not assured of the continuance of the indemnification * * * by the payment of renewal premiums at the expiration of the term covered by each premium.

"All of respondent's policies [listed in the complaint] contain substantially identical provisions as follows:

" 'This policy is renewable at the option of the association only * * *' "

2. MISREPRESENTATION OF EXTENT OF COVERAGE

The claim

"Accident benefits include $50 weekly payable from the first day of total disability every 30 days for as many as 104 weeks for *each* mishap * * * $25 weekly for as many as 26 weeks for partial disability * * * as much as $5,200 for each accident, with no reduction on account of other insurance."

The facts

"The weekly benefits described * * * are not payable for each mishap or accident from the first day of total disability for as many as 104 weeks nor up to a maximum of $5,200, for the certificates referred to expressly provide that:

"(*a*) No weekly benefits are payable by respondent for total disability caused by 'each mishap' or 'each accident' unless 'such injuries alone shall, within 20 days after the date of the accident causing them or immediately following a period of partial disability insured against and caused by said accident, wholly and continuously disable him from the prosecution of every duty pertaining to his occupation.'

"(*b*) No weekly benefits are payable by respondent for partial disability caused by 'each mishap' or 'each accident' unless 'such injuries alone shall, within 20 days after the date of the accident causing them or immediately following a period of total disability insured against and caused by said accident, partially disable and prevent him from performing the important duties of his occupation.'

"(*c*) No accident benefits, weekly or otherwise, are payable, for any loss whenever occurring, if such loss was caused 'directly, indirectly, wholly or partially by or to which a contributing cause is:

" '(a) medical, surgical or dental treatment; or

" '(b) any kind of sickness, disease, or bodily or mental infirmity; or

" '(c) sunstroke, heatstroke, ptomaine poisoning, or bacterial infection of any kind (except only septic infection of and through an external and visible wound caused solely and exclusively by external and accidental violence); or

" '(d) hernia, however caused, except in a sum not to exceed $100.'

"(*d*) The exceptions contained in the certificate of accident coverage provide that no benefit shall be paid for any loss caused by suicide, or attempt to commit suicide, any loss caused by war or any act of war, any loss occurring or originating while a member is outside the continental limits of the United States and Canada unless a travel permit or a permit to reside elsewhere is first granted in writing by the respondent, or while engaged in military or naval service in time of war declared or undeclared, or while insane, or while intoxicated or under the influence of narcotics.

"(*e*) No benefit is paid for a loss caused by an accident unless such loss occurs within 90 days of the date of such accident."

3. MISREPRESENTATION OF MAXIMUM DOLLAR LIMITS

The claim

"Surgery from $3 to $150 depending on seriousness of operation."

The facts

"Policy AE Rev. 9–52 provides for the payment of $150 for surgeons' fees for only 6 out of 67 different listed operations. For 29 of the listed operations, $25 or less is allowed."

4. MISREPRESENTATION OF BEGINNING TIME OF COVERAGE

The claim

"Benefits from the first day."
"Pays from the first day of medical attention."
"Monthly lifetime income is paid from the first day of disability."
"Full benefits payable from the very first day of disability and medical attention."
"Accidental benefits in effect the same day policy issued."
"A new plan that pays you a large monthly income from the first day you are disabled at home."

The facts

"Indemnification is not provided from the first day of sickness or accidental injury; on the contrary, the policies provide that indemnification will be provided only for sickness originating more than 30 days after the policy date and only from the date of the first medical attention. Diseases of organs not common to both sexes, and diseases of the heart, or circulatory system, will be covered only if originating after the policies have been in effect for periods of from 6 to 12 months, depending on the individual policy. The policies further provide indemnification for accidents only from the date of the first medical treatment and such indemnification will be paid only for accidental injury which shall within 2 days from the date of said accident wholly and continuously disable the insured and cause total loss of time and regular attendance of a licensed physician, surgeon, osteopath, or chiropractor for the duration of the disability, and does not result in loss of life, limbs, or eyesight."

5. MISREPRESENTATION CONCERNING HEALTH STATUS OF APPLICANT

The claim

"No redtape—You don't have to join a group or be examined."
"No physical examination needed."

The facts

"The respondent does take into consideration the physical condition of the insured prior to or at the time the policy was issued in determining whether or not the cash benefits provided * * * will be paid for loss resulting from sickness or accident after the effective date. The insuring clause * * * provides that sickness shall be such sickness, illness, or disease which is contracted and begins and causes loss 30 days after the date of issue or from the date of issue. Further, in Policies P64A, P67B, and P66A the insuring clause provides that accidental loss must be effected directly and independently of all other causes through accidental injury."

6. MISREPRESENTATION CONCERNING SALE OF A PLAN

The claim

"Here's what you get. Streamlined, all-family plan issued by old-line, legal-reserve stock company, lowers cost—cuts redtape—pays you promptly and pays you more. Up to:
"$1,800 for hospital room.
"$5,000 for loss of life.
"$500 for surgery fees.
"$200 per month when off work due to accidental or totally confining sicknesses.
"$115 for childbirth.
"$150 per year for doctor's calls in the home or hospital.
"All this wonderful coverage costs you less than most folks spend for smokes."

The facts

" 'The reserve plan' providing benefits in the form of cash indemnification for a whole family to a maximum of $1,800 for hospital room, $5,000 for loss of life, $500 for surgery fees, $200 per month for loss of time from work, $115 for child-

birth, and $150 per year for doctor's calls to each or for each member of the family for each accident or sickness, are not contained in a single policy at a cost less than the average person spends for smokes. On the contrary, the described cash benefits of respondent's 'reserve plan' are simply a totalization of the maximum cash benefits contained in three or more of respondent's policies. and such cash benefits, if obtainable at all, would require the purchase of three or more of respondent's policies."

7. MISREPRESENTATION OF BENEFITS AS PAYABLE FOR LIFE

The claim

"What will it mean to you to have $100 a month for the rest of your life, if totally disabled by sickness or accident?"

"Pays up to $100 per month income for the rest of your life * * * payable as long as you are disabled and cannot work because of any accident or any confining sickness."

The facts

These "insurance policies do not provide monthly indemnification, in a specific amount, to the insured when totally disabled by any accident or confined by any sickness for the duration of such total disability or confining sickness up to a life time. On the contrary, many disabling accidents and confining sicknesses which the insured may suffer or contract are excluded * * *.

"The terms of [the] policies not only require that the insured be disabled in case of accident but provide that the disability must wholly and continuously prevent the insured from performing the duties of any occupation, and require the professional care and regular attendance of a physician or surgeon.

"If the insured receives one of the cash benefits for the loss of limb or sight, no monthly indemnification will be paid to the insured. Loss resulting from sprain or lame back will receive the represented indemnification for only 30 days. Certain * * * policies reduce the specific amount of the indemnification when the insured reaches a stated age."

8. MISREPRESENTATION CONCERNING ADDITIONAL BENEFITS

The claim

"In addition to the above, will pay the following accident benefits:

Loss of life	$1,000
Loss of both hands, feet, or eyes	1,000
Loss of 1 hand and 1 foot, 1 hand and 1 eye, or 1 foot and 1 eye	1,000
Loss of 1 hand or 1 foot	500
Loss of 1 eye	300
Loss of time, weekly indemnity (employed members in hospital) $25 a week—up to	300
Doctor bills (hospital) up to	135"

The facts

"None of the respondent's policies provide benefits, in addition to hospitalization benefits, for specific amounts for loss of life, limb, sight, loss of time if employed, and doctor bills up to $135 when confined in a hospital, to the insured because of any one accident. On the contrary the respondent's form PFGH 4–45 provides benefits for hospitalization, loss of life, limb and sight, loss of time if employed, and doctor bills up to $135 when confined to a hospital, but to recover benefits in specific amounts for loss of life, limb, or sight the insured must receive bodily injury caused directly and independently of all other causes, through external, violent and accidental means and within 90 days from the date of the accident whereby the insured suffered the specific loss. Any benefit received for a specific loss will be in lieu of all other benefits. If the insured is not confined in a hospital within 5 days from the date of accident and has not had full-time employment for at least 4 consecutive months immediately preceding the date of hospital confinement, the insured will not receive the loss of time benefit. [The] policy does not indemnify the insured $135 for doctor bills in case of accident but provides $3 per professional visit on each alternate date of hospital confinement to a maximum of $135 provided the insured is confined in a hospital within 5 days from date of accident."

Orders to cease and desist

Docket No.	Company	Date OCD	Affirmed
6241	Commercial Travelers Insurance Co	Jan. 27, 1955	
6245	Illinois Commercial Men's Association	Sept. 23, 1955	
6278	Service Life Insurance	Dec. 28, 1955	
6454	Illinois Traveling Men's Health Association	Sept. 25, 1956	
6238	American Life & Accident Insurance Co	Apr. 19, 1957	May 16, 1958
6239	Automobile Owners Safety Insurance Co	Apr. 26, 1957	Do.
6237	American Hospital & Life Insurance Co	Apr. 24, 1956	June 30, 1958
6252	Travelers Health Association	Dec. 20, 1956	Jan. 24, 1962
C-726	Guarantee Reserve Life Insurance Co. of Hammond	Mar. 25, 1964	

NOTE.—Cases on which an assurance of discontinuance has been accepted, 6; cases under investigation 11.

FEDERAL TRADE COMMISSION, WASHINGTON

GUIDES FOR THE MAIL ORDER INSURANCE INDUSTRY

Guides for the Mail Order Insurance Industry as adopted by the Federal Trade Commission are hereinafter set forth.

Primary objectives of the Guides are the prevention of deception of purchasers of insurance and the maintenance of fair competition in the industry.

The industry for which these Guides have been established is comprised of the persons, firms, corporations and organizations engaged in the sale or offering for sale of insurance of any kind in commerce[1] by means of the United States mails in any State in which they are not licensed to conduct the business of insurance, or in which, though licensed, they do not have any agents. The Guides are applicable to all advertising and sales promotions of insurance sold under such circumstances. The establishment and promulgation of such Guides by the Commission is not to be understood as delimiting the jurisdiction of the Commission with respect to the business of insurance under the Clayton Act and Federal Trade Commission Act as such Acts are affected by Public Law 15—79th Congress, as amended.

These Guides were published in the Federal Register on ——— and become effective sixty (60) days thereafter.

THE GUIDES

DEFINITIONS

A. "Advertisement" for the purpose of these Guides shall mean any of the following material when used in connection with solicitation of the original purchase of a policy, or renewal or reinstatement thereof:

(1) Any printed or published material, descriptive literature, statements or depictions of an insurer used in newspapers, magazines, radio and TV scripts or presentations, billboards, and similar displays, and

(2) Descriptive literature and sales aids of all kinds issued or caused to be issued by an insurer or by an insurer's agent or broker for presentation to members of the public, including, but not limited to, circulars, leaflets, booklets, depictions, illustrations, form letters, and policy forms.

B. "Policy" for the purpose of these Guides shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides insurance benefits for any kind of loss or expense.

C. "Insurer" for the purpose of these Guides shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, and any other legal entity, engaged in the advertisement and sale of a policy as herein defined.

Guide 1—*Deception (General)*

No advertisement shall be used which because of words, phrases, statements, or illustrations therein or information omitted therefrom has the capacity and tendency to mislead or deceive purchasers or prospective purchasers, irrespective of whether a policy advertised is made available to an insured prior to the

[1] As "commerce" is defined in the Federal Trade Commission Act.

consummation of the sale, or an offer is made of a premium refund if a purchaser is not satisfied. Words or phrases which are misleading or deceptive because the meaning thereof is not clear, or is clear only to persons familiar with insurance terminology, shall not be used.

Guide 2—*Advertisement of Benefits, Losses Covered, or Premiums Payable*

A. *Disclosure as to Exceptions, Reductions, and Limitations*

No advertisement shall refer to any loss covered or benefit provided by an insurance policy, period of time for which any benefit is payable, or the cost of a policy, without clearly and conspicuously disclosing in close conjunction therewith such exceptions, reductions, and limitations relating thereto as will fully relieve the advertisement of all capacity to deceive.

The disclosure requirements of this Guide 2 are not applicable to advertisements which mention only the general kind of insurance (e.g. "Life," "Accident," "Hospitalization"), give no information as to losses covered, benefits or premiums, and serve the purpose of merely inviting inquiries or a show of interest on the part of the recipients.

As used in this Guide—

The term "exception" means any provision in a policy whereby coverage for a specified hazard is entirely eliminated. It is a statement of risk not assumed under the policy.

The term "reduction" shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction clause not been used.

The term "limitation" means any provision which restricts the duration or extent of coverage, losses covered, or benefits payable under the policy other than an exception or a reduction.

(1) *Waiting, Elimination, Probationary, or Similar Periods*

When there is a time period between the effective date of a policy and the effective date of coverage under the policy, or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, such fact must be clearly and conspicuously disclosed in close conjunction with any reference to such coverage or benefits made in any advertisement.

(2) *Benefits Contingent on Conditions*

When a policy pays varying amounts of benefits for the same loss occurring under different conditions or which pays benefits only when a loss occurs under certain conditions, any reference to such benefits in an advertisement must be closely accompanied by clear and conspicuous disclosure of such different or limited conditions as are applicable.

(3) *Preexisting Conditions*

If a policy provides any limitations on the coverage of a loss if the cause of such loss is traceable to a condition existing prior to the effective date of the policy, or prior to any other particular time, any reference to the policy coverage of the loss made in any advertisement must be closely accompanied by clear and conspicuous disclosure of such limitations. (See also Guide 3.)

(4) *Deceptive Words or Phrases*

(a) No words, terms, or phrases shall be used as descriptive of the coverage provided by a policy which misrepresent the extent of such coverage. Words such as "all," "full," "complete," "unlimited," and words of similar import must not be used to refer to any coverage which under the terms of the policy is subject to exceptions, reductions, or limitations. Other words, terms, or phrases representing or implying broad insurance coverage must not be used as descriptive of losses covered or benefits provided by a policy which are subject to exceptions, reductions, or limitations without disclosure of the applicable exceptions, reductions, or limitations as required by Part A of this Guide 2.

(b) The terms "hospitalization," "accident," or "life" must not be used as descriptive of an insurance policy which provides benefits for only unusual or unique sicknesses, accidents, or causes of death unless in close conjunction with such terms clear and conspicuous disclosure is made of such coverage (e.g., "Leukemia Hospitalization," "Death by Drowning").

(c) Words or phrases such as "up to," "as high as," etc., shall not be used as descriptive of the dollar amount payable for any kind of represented losses

or expenses *unless* the policy provides benefit payments up to such amount in all cases for such losses or expenses actually sustained by a policyholder, *or* there is full and conspicuous disclosure in close conjunction with such words or phrases of either—

(1) the complete schedule of payments provided by the policy, or

(2) the specific loss or expense for which the represented dollar amount is provided by the policy; and also disclosure that benefits provided by the policy for losses or expenses of the kind represented vary in amount depending on the particular kind of loss or expense incurred, if such is the case, as for example:

"Policy provides surgical benefits which vary in amount depending on kind of operation performed. For example, pays up to $150 for operation to remove a lung."

and there is also disclosure of such other exceptions, reductions, or limitations as required by Part A of this Guide 2.

(d) An advertisement must not contain representations such as "This policy pays $1,800 for hospital room and board expenses" without clear and conspicuous disclosure in close conjunction therewith of the maximum daily benefit and the maximum time limit for such hospital room and board expense.

(e) An advertisement must not represent the weekly, monthly, or other periodic benefits payable under a policy without clearly and conspicuously disclosing in close conjunction with such representation the limitation of time over which such benefits will be paid or of the number of payments or total amount thereof which will be made if, by the terms of the policy, payment of benefits for any loss or aggregate of losses is limited in time, number, or total amount.

(5) *Age Limitation*

Any reference in an advertisement to any insurance coverage or benefits which by the terms of the policy are limited to a certain age group must be closely accompanied by clear and conspicuous disclosure of such fact.

B. *Deception as to Coverage and Additional Benefits*

(1) A policy covering only one disease or certain specified diseases must not be advertised in such manner as to imply coverage beyond the terms of the policy, either by use of synonymous words or terms to refer to any disease or physical condition so as to imply broader coverage, or by other means.

(2) An advertisement must not represent, directly or indirectly, that a policy provides for the payment of certain benefits in addition to other benefits when such is not the fact.

Guide 3—*Health of the Applicant or Insured*

No advertisement shall be used which represents or implies:

(1) That the condition of the applicant's or insured's health prior to, or at the time of issuance of a policy, or thereafter, will not be considered by the insurer in determining its liability or benefits to be furnished for or in the settlement of a claim when such is not the fact (See also Part A(3) of Guide 2); or

(2) That no medical examination is required if the furnishing of benefits by an insurer under a policy so represented is or may be contingent on a medical examination under any condition; or

(3) That no medical examination is required, even though such is the case, without conspicuously disclosing in close conjunction therewith all the conditions pertaining to or involving the insured's health under which the insurer is not liable for the furnishing of benefits under a policy.

Guide 4—*Disclosure of Policy Provisions Relating to Renewability, Cancelability, or Termination*

(a) No advertisement shall refer, directly or by implication, to renewability, cancellability, or termination of a policy or a policy benefit, or contain any statement or illustration of time or age in connection with any benefit payable, loss, eligibility of applicants, or continuation of a policy, unless in close conjunction with such reference, statement, or illustration there is clear and conspicuous disclosure of the material provisions in the policy relating thereto.

(b) No advertisement shall represent or imply that an insurance policy may be continued in effect indefinitely or for any period of time, when, in fact, said policy provides that it may not be renewed or may be canceled by the insurer,

or terminated under any circumstances over which insured has no control, during the period of time represented.

Guide 5—*Testimonials, Appraisals, or Analyses*

No testimonial, appraisal or analysis shall be used in any advertisement which is not genuine, does not represent the current opinion of the author, does not accurately describe the facts, does not correctly reflect the present practices of an insurer, is not applicable to the policy or insurer advertised or is not accurately reproduced.

(NOTE.—An insurer makes as his own all statements contained in any testimonial which he uses in his advertisement, and the advertisement including such statements is subject to all of the provisions of these Guides.)

Guide 6—*Deceptive Use of Statistics*

(a) No advertisement shall be used in which representations are made as to the time within which claims are paid, the dollar amounts of claims paid, the number of claims paid or the number of persons insured under a particular policy or otherwise, or which contains other statistical information relating to any insurer or policy, unless such advertisement accurately reflects all the relevant facts. The advertisement shall not imply that the statistics are derived from a policy advertised unless such is the fact.

(b) No advertisement shall be used which misrepresents that claim settlements by an insurer are liberal or generous beyond the terms of a policy.

Guide 7—*Identification of Plan or Number of Policies*

(a) No advertisement shall offer a choice of the amount of benefits without clearly and conspicuously disclosing that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of benefits.

(b) No advertisement shall refer to various benefits which may be contained in two or more policies, other than group master policies, without clearly and conspicuously disclosing that such benefits are provided only through a combination of such policies.

Guide 8—*Deception as to Introductory, Initial, or Special Offers*

No representation shall be made in an advertisement, directly or by implication, that a policy or combination of policies is an introductory, initial, special or limited offer and that applicants will receive advantages not available at a later date, unless such is the fact.

Guide 9—*Misrepresentation as to Licensing, Approval, or Endorsement of Insurer, Policy or Advertisement*

No advertisement shall represent directly or by implication:

(1) That an insurer, or any policy or advertisement thereof, has been licensed, approved, endorsed, or recommended by any Governmental agency or department, unless such is the fact;

(2) That an insurer, or a policy or an advertisement thereof, has been approved, endorsed, or recommended by any individual, group of individuals, society, association, or other organization, unless such is the fact.

Guide 10—*Deception as to "Group" or "Quasi-Group" Policies*

No advertisement shall represent, directly or indirectly, that prospective policyholders become group or quasi-group members and as such enjoy special rates or underwriting privileges ordinarily associated with group insurance as recognized in the industry, unless such is the fact.

Guide 11—*Allocation of Benefits Under a "Family Group" Policy*

No advertisement shall refer to a benefit payable under a "Family Group" policy when the full amount of such benefit is not payable upon the death, disability, etc., of only one member of the family unless clear and conspicuous disclosure of such fact is made in the advertisement.

Guide 12—*Deceptive Use of Trade Names, Service Marks, etc.*

There shall not be used in an advertisement any trade name, service mark, slogan, symbol, or other device which has the capacity and tendency to mislead or deceive prospective purchasers as to the true identity of the insurer or its relation with public or private institutions.

Guide 13—*Disparagement*

No advertisement shall be used which, directly or indirectly, falsely disparages competitors, their policies, services, or business methods.

Guide 14—*Misrepresentation Concerning the Insurer*

No advertisement shall be used which, directly or by implication, has the capacity and tendency to mislead or deceive prospective purchasers with respect to an insurer's assets, corporate structure, financial standing, age, or relative position in the insurance business, or in any other material respect.

(Transcript text continued from p. 7.)

Senator WILLIAMS. These guides that you have just described to us are the new guides that will be shortly put into effect; is that correct?

Mr. HENDERSON. That is correct, sir.

Senator WILLIAMS. What has been your practice heretofore; what is it still? Does it follow pretty much the philosophy of these guides?

Mr. HENDERSON. Yes, sir. These guides are simply a formalization of the thinking of the Commission over a period of a great number of years and we simply felt that the time was opportune to revise and codify this thing for the benefit of the aged, the elderly, and for the general public.

Senator WILLIAMS. When you discover a misrepresentation within the terms that you have just discussed, can you move in in any case or only in some cases to stop the deception?

Mr. HENDERSON. In a very limited number of cases, Senator, can we move in. That is only in those cases where it is a mail-order operation which is not effectively regulated by the State into which the mail-order advertisement is sent.

Senator WILLIAMS. Are there large gaps where a State has not regulated? Certainly the State has the authority to regulate any company disseminating advertising material from its jurisdiction, does it not?

Mr. HENDERSON. Oh, yes.

To answer your question, we have 11 investigations going at the present time to ascertain our jurisdiction to prevent alleged deception in the sale of insurance where we believe that the States do not have the capacity to effectively regulate these companies.

The illustration that is a good one is the *Travelers* case where this company was licensed to do business in only two of the 50 States, but it was advertising in all 50 of the States, so that 48 States had no way of effectively controlling the mail flow into its own bailiwick.

Senator WILLIAMS. But the other two States would have the jurisdiction to control the outflow from their borders; is that right?

Mr. HENDERSON. Not the outflow of mail; I doubt it, Senator. Because this is a Federal function, and I doubt that a State could say you cannot send mail out of the State. It would have to be at the other end, at the recipient's end where to the company, the State can say you must come in here and take a license and you must have an agency for service at that point and then it can also say this is fraudulent advertising.

Senator WILLIAMS. Then there are large gaps and in these gaps you have authority to deal with misrepresentations?

Mr. HENDERSON. Yes, sir.

Senator WILLIAMS. What is the method used to stop it?

Mr. HENDERSON. Depending on the abuse and on the past history of the company. If this seems to be an inadvertent type of thing, the company may have fallen into by an overzealous advertising manager, we may ask them to give us assurances of discontinuances of the practice. This is simply an assurance that they will abandon this particular practice and will abide by the guides. If this is a company which is noted for its predatory practices, its fraudulent representations, we would probably file a formal complaint against it and either insist on a consent order to try the case and enter an order of the Commission which would forbid it from continuing these practices.

That order is litigated, but a consent order would be enforcible by the courts as well.

Senator WILLIAMS. This is an injunctive method of dealing with them?

Mr. HENDERSON. That is correct, sir.

Senator WILLIAMS. Is that a criminal or civil and is there a jury trial?

Mr. HENDERSON. No, sir; it is a civil proceeding before a hearing examiner and before the Commission and it is reviewable by any circuit court of appeals in which the person complained of lives or does business.

We have no punitive powers at all; we cannot fine or penalize them except for disobedience of an entered order. At that point there are penalty provisions and, of course, if the court has made its own order in the case, then the respondent is subject to a criminal contempt proceeding.

Senator WILLIAMS. What are the penalties that are possible if there is a finding of contempt?

Mr. HENDERSON. That maximum is $5,000 per violation. The total amount to be levied is within the judgment of the court.

Senator WILLIAMS. I would think that would be an effective remedy.

Mr. HENDERSON. It has proved so in some cases, but you first have to catch them.

Senator WILLIAMS. We have seen some remedies that are very ineffective in terms of their severity. In one of the Western States, it would almost pay those who wanted to be unlawful. They make more money in jail than they had to pay in fines.

Senator Fong?

Senator FONG. Does the Federal Trade Commission Act give you the power to take action against unfair advertising?

Mr. HENDERSON. Yes, sir, in commerce.

Senator FONG. Do you consider this commerce?

Mr. HENDERSON. Yes, sir.

Senator FONG. Therefore, you have the power to actually take action against these companies which used fraud in advertising?

Mr. HENDERSON. Only in this limited field that I have described, Senator; that is where the company is using the mail and is mailing these fraudulent advertisements into States where they are not licensed to do business and they have no agent for service.

Senator FONG. Do you go to court and ask for an order to desist?

Mr. HENDERSON. No, sir.

The Commission has the power under the Federal Trade Commission Act to issue its own order to cease and desist. The order is reviewable by the courts.

Senator FONG. If they refuse to desist, what is your power?

Mr. HENDERSON. We then have the alternative of taking them into court on a contempt charge or take them to court for civil penalties.

Senator FONG. What about the criminal penalties as far as general law or misrepresentation is concerned?

Mr. HENDERSON. You would have the postal regulations and then you would have your general fraud statutes.

Senator FONG. Would these frauds come under the general fraud statutes?

Mr. HENDERSON. I think many of them would.

Senator FONG. Do you have general powers now to punish the individual companies that insist on carrying on deceptive advertising?

Mr. HENDERSON. Only within the limitations of the McCarran-Ferguson Act.

Senator FONG. What is that act?

Mr. HENDERSON. McCarran-Ferguson Act of 1945, which says that the Commission shall regulate the insurance industry only where it cannot be effectively regulated by the States. The *Travelers Insurance* case, which went to the Supreme Court, delineated what was considered to be effective regulation.

Senator FONG. Over and above the Ferguson-McCarran Act, do you have the power, if you wish to exercise it, of going to the Attorney General and asking him to bring criminal proceedings because of misrepresentations?

Mr. HENDERSON. If it falls within the fraud statute we would probably certify to the Attorney General or to the Post Office Department, who in turn might certify it.

Senator FONG. In all of these misrepresentations, which you have enumerated relative to cancelability, and relative to the amount of aid that is being offered and the amount of premiums, can these misrepresenations be taken care of by the general statutes?

Mr. HENDERSON. I am not sure they can effectively, Senator. There are some of them that certainly can. I do not know just how far the Post Office Department has explored its authority in this field and how far it has exerted authority. I am just not expert on the mail-order frauds.

Senator FONG. Would you say that the powers of the Attorney General under the general laws would be sufficient to take care of a substantial number of fraudulent practices which you have enumerated?

Mr. HENDERSON. I do not think that the U.S. fraud statute would possibly take care of them. Your State fraud statutes could possibly do it, but the fraud would be against an individual rather than against the United States, you see. And it would make a rather dubious sort of case, I would think, if the Attorney General attempted to apply a blanket indictment to some of these misrepresentations.

Senator FONG. Do you have sufficient power to ask them to cease and desist?

Mr. HENDERSON. Within the limitations of the McCarran-Ferguson Act; yes, sir.

Senator FONG. You have no jurisdiction over those who are licensed to do business in a State and have agencies in the State—is that right?

Mr. HENDERSON. That is right.

Senator FONG. If the States would adopt the rules and regulation guides which you have proposed, would that be very helpful?

Mr. HENDERSON. It would be very helpful; yes, sir. And I would assume they do follow similar guides in most of the States, if not all of them. I believe you have some State commissioners here that could give you more information than I could on that.

Senator FONG. Is it correct, sir, that the companies that are now engaged or contemplating engaging in any health insurance business are companies already in existence having as their sole business or primary business, life insurance; or would you say these companies now being born are going into the health insurance field as their primary business?

Mr. HENDERSON. I do not think we have any statistics on it.

Senator, we have no reliable satistics on that.

I would say that there are a number of new companies being formed simply because of the demand for this type of insurance; but it is certainly true, I am sure, that the vast bulk of this is being sold by companies who have been in existence.

Senator FONG. This would be an adjunct to the business of life insurance that they already have?

Mr. HENDERSON. Yes.

Senator FONG. And are these companies regulated by State statutes or by various other regulations?

Mr. HENDERSON. Wherever they are licensed; yes, sir.

Senator FONG. Would you say that as far as these misrepresentations are concerned they are numerous in the field of insurance, or would you say that it is only a nominal problem?

Mr. HENDERSON. I would say that most of your—the vast majority of your insurance companies—do not indulge in these practices, but as most laws are made, they are made to control those few who are predatory and who do defraud the public. This is not only true of the Federal Trade Commission Act but our criminal acts and most of your regulatory laws.

So, it is quite a heartbreaking thing to see, and I have an incident at my own office: the man is a lawyer and he has not lost a case for us yet, but he failed to read the insurance clauses in his mother's contract. She had a heart attack and she was still in the hospital. She had a second heart attack a number of weeks later and died. He found out she was not insured at all. There was a waiting period in the contract and she simply was not covered, so he had a rather tremendous hospital bill and doctor bill there that he had not anticipated.

Senator WILLIAMS. He was a lawyer, did you say?

Mr. HENDERSON. Yes, sir.

Senator WILLIAMS. Even a lawyer can do that?

Mr. HENDERSON. Yes, sir.

Senator FONG. I know we all are appalled by the fact that when we find ourselves in the position of trying to get the benefits, the small print is sometimes there saying that we are not entitled to these benefits.

Mr. HENDERSON. That is right.

Senator FONG. Naturally every one of us would like to see that these practices are taken care of.

I am trying to find out the extent of the practices, whether they are very, very numerous or whether they are not as numerous, but regardless of whether they are numerous or not, the effect on the individual naturally is catastrophic in many cases.

Coming back to the question of whether they are numerous or not, am I correct when I say that most of the health insurance policies that are now being written by insurance companies are being written by companies who are already in the insurance field and have been in the insurance field for a long time?

Mr. HENDERSON. Senator, I do not have the statistics on that, but I am quite sure your statement is correct, just because of the fact that they do have the organization set up to sell and a new company just coming into the field is going to have a problem, of course, of getting salesmen and this is one of the problems, too, getting reputable salesmen who are trained to properly sell insurance. But to answer your question, I am sure that the vast majority of this insurance is being sold by companies who are and have been in existence.

Senator FONG. Are most of the health policies being sold by Blue Cross?

Mr. HENDERSON. It has the reputation, I think, of being the largest of the companies.

Senator FONG. We have had testimony before this committee that over 60 percent of the health insurance policies are being sold by Blue Cross.

So, the predatory companies which carry on such nefarious practices of misrepresenting their policies are not as many or do not constitute a large proportion of the industry?

Mr. HENDERSON. Again, Senator, we have no statistics but I am sure that is a correct statement.

Senator FONG. As I understand, there are approximately 200 insurance companies out of the thousand and some-odd companies that are engaged in health insurance policy writing.

Mr. HENDERSON. I have no figure on that.

Let me explain why we do not have this type of information. We have not made a composite survey of the insurance industry such as we have in a number of other industries. Our information comes only when someone complains or writes in a letter and says that this company sold me this policy and I did not know that I did not carry insurance; so we have no statistics other than to know that we have a goodly number of complaints, but what that represents in the total sales of policies we have no figures.

Senator FONG. Thank you, Mr. Henderson; there is a quorum call and I have to answer it, so I will recess this hearing until Senator Williams comes back.

(Recess.)

Senator WILLIAMS. We can reconvene and we hope we will have no further interruptions.

Senator Keating?

Senator KEATING. Mr. Henderson, if a policy is sold by mail in a State where the company is not licensed, how can the State insurance commission control a fraudulent case?

Mr. HENDERSON. Well, it is our belief, shared by the Supreme Court, that they cannot effectively control it, Senator. This is the one area where we continue to operate in the insurance industry.

Senator KEATING. There has been a decision on that?

Mr. HENDERSON. Yes, sir, the Traveler's Insurance Co. of 1954. We have just last month issued a consent order against another company for similar practices.

We have approximately 11 investigations going in this field today; we have 9 outstanding orders.

Senator KEATING. Where are most of these companies located?

Mr. HENDERSON. I think they are fairly widespread. We find a number of them in the Middle West, the West, and Southwest. But to say that they have a monopoly in that area is not true. We just do not know, I guess is a better answer to your question. The ones that we seem to find so far and where the complaints are coming from are in those areas.

Senator KEATING. I had one of these small print experiences myself so I am very interested in cases where one has a policy and puts in a claim only to find that he is not covered under that policy.

Mr. HENDERSON. This may be years or months later, you see, too, where you have been under the illusion you have something you do not have.

Senator KEATING. In my case I had been paying premiums for years, and the company was perfectly right; it is just that I did not realize what the policy said.

Now, how are you going to make people read the fine print?

Mr. HENDERSON. It is very difficult. We hope that the guides will be of some assistance in that field. It is an educational process, but as the courts have said the predatory tactics are limited only by the ingenuity of the salesman and of the company. We think it is going to be a very difficult problem to cope with.

Senator KEATING. If these guidelines are adopted—they are not yet adopted, are they?

Mr. HENDERSON. Yes, sir; they have been adopted by the Commission and will be published in the Federal Register, but, of course, they have no probative effect; they are simply suggested as a sort of code of ethics.

Senator KEATING. That was my next question.

Is there any sanction available to see that these guides are adhered to by the industry?

Mr. HENDERSON. No, sir; simply that the industry knows what we consider to be violations of the law and what we consider to be good conduct, and they are forewarned that we will move in if we discover violations of these guides. But we still have to prove our case.

Senator KEATING. I think that is all, Mr. Chairman.

Senator FONG. Mr. Henderson, in your Commission, how many orders of cease and desist have you issued against insurance companies who have fraudulent health insurance representations?

Mr. HENDERSON. Senator, I believe we have issued either orders or assurances to discontinue in a total of approximately 15 cases.

Senator FONG. And of these 15 cases, how many companies are involved?

Mr. HENDERSON. There would be 15 companies.

Senator FONG. And there are approximately 200 companies in the field?

Mr. HENDERSON. That is my understanding, Senator. I have no personal knowledge of that.

Senator FONG. Are you working on many cases now?

Mr. HENDERSON. We have 11 investigations actively under investigation at this time.

Let me explain, Senator. We have been virtually out of this area up until quite recently, since the McCarran Act was passed; we simply thought if the complaints were not coming in, that this was an area we would leave to State regulation.

As this new type of insurance is now becoming popular, more complaints are coming to us. This accounts in part for the fact that we have no more investigations going than we do.

Senator FONG. Do these 11 complaints that you are working on involve the same 15 companies?

Mr. HENDERSON. No; these are new companies, additions—I do not mean new; they are new complaints, not necessarily new companies.

Senator FONG. You have approximately 26 complaints on 26 various companies?

Mr. HENDERSON. Right, sir.

Senator FONG. Thank you.

Senator WILLIAMS. I believe that will be all, gentlemen.

For the committee I want to thank all of you.

Mr. HENDERSON. To give you a complete answer to your question, Senator Fong, we have had a considerable number of applications for investigations where we quickly found that we had no jurisdiction; that these were matters which could be and should be regulated by the States within the terminology of the McCarran Act. Where we have those, we refer them to the various State insurance commissioners.

Senator WILLIAMS. Thank you.

Next, we would like to have a group of three witnesses come up; they will all be talking to the same general subject matter.

Representative Ronald Brooks Cameron, from the 25th District of California; is Whittier your hometown?

Mr. CAMERON. Yes, Mr. Chairman.

Senator WILLIAMS. It has changed its complexion.

Mr. CAMERON. Yes, sir; it is well represented.

Senator WILLIAMS. Charles James, deputy attorney general for the State of California; and I have personal pride in introducing Robert Peacock, secretary-director of the New Jersey Real Estate Commission.

I got pretty close to sitting over there with you one year, Congressman.

Now, have you gentlemen worked out your presentation? You may proceed any way you want, Congressman.

STATEMENT OF REPRESENTATIVE RONALD BROOKS CAMERON, 25TH DISTRICT OF CALIFORNIA

Mr. CAMERON. Thank you, Mr. Chairman. I want to commend you and your committee for undertaking this investigation. In my judgment, a serious study at the congressional level relating to deceptive and misleading—if not fraudulent—practices in the sale of health and accident benefits is long overdue.

The word "benefits" I use advisedly, for many purveyors of health and accident benefits are not operating as insurance companies—which in the main are reasonably well regulated by the several States—but rather operate under the guise of providing direct service—service available only through preselected physicians and preselected locations.

During my service in the California Legislature, I served continually as chairman of a study committee dealing in this general area—and with your permission, Mr. Chairman, I would like to submit for the record two of the reports published by my committee. I have them here with me.

(The reports referred to follow:)

(Text continues on p. 70.)

REPORT ON HEALTH INSURANCE

House Resolution No. 284 of the 1959 Regular Session read as follows:

Resolved by the Assembly of the State of California, That the subject matter of group insurance plans providing medical and hospital insurance coverage and their relation to the costs of hospital services and medical care in the State of California is assigned to the Committee on Rules for further assignment by it to an appropriate Assembly interim committee, which committee is directed to report to the Assembly on such subject matter not later than the fifth calendar day of the 1961 Regular Session of the Legislature.

This subject was subsequently assigned to the Committee on Finance and Insurance by the Rules Committee. Assemblyman Ronald Brooks Cameron was requested by Chairman Rees to make a study of the matter and, upon conclusion, report to the full committee.[1]

At its meeting in Sacramento on December 6, 1960, the committee adopted the following recommendation:

Immediately after commencement of the 1961 Regular Session of the Legislature we recommend the creation of a subcommittee of an appropriate committee to continue the study in the entire field of prepaid hospital and medical care with authority for the subcommittee investigation to run concurrently with the 1961 Legislative Session and appropriation by the Rules Committee of sufficient funds for the subcommittee to maintain a full-time legislative consultant and a full-time legislative secretary.

[1] The report made to the committee by Assemblyman Cameron is included in the Appendix to this report.

APPENDIX

MEDICAL AND HOSPITAL INSURANCE COVERAGE

LETTERS OF TRANSMITTAL

HONORABLE SPEAKER OF THE ASSEMBLY
HONORABLE MEMBERS OF THE ASSEMBLY
Assembly Chamber, State Capitol
Sacramento, California

The following report on medical and hospital insurance was submitted by Assemblyman Ronald B. Cameron.

House Resolution No. 284 of the 1959 General Session, which directed an appropriate interim committee to study the subject of group insurance plans providing medical and hospital insurance coverage, was assigned to the Finance and Insurance Committee by the Assembly Rules Committee.

Because this was a technical field which has not been covered in recent years by this committee, it was decided by the chairman to ask Assemblyman Cameron to prepare a report to help the committee in defining its scope in this general area.

Assemblyman Cameron's report was submitted to the committee at its hearing on December 6, 1960. The committee does not approve or disapprove of the report, and it is to be emphasized that this report contains the findings of one member and that this subject has not been covered at public hearings. It was the desire of the committee to have this report in the Appendix of the interim committee's final report. Also, a specific recommendation of the interim committee relating to full-scale public hearings has been printed in the body of the full report.

Sincerely yours,

THOMAS M. REES

November 30, 1960

To: All Members, Assembly Interim Committee on Finance and Insurance

In response to many complaints from constituents regarding the shortcomings of their prepaid hospital and medical insurance coverage, I introduced House Resolution No. 284 on May 26th, 1959, which resolution was passed unanimously by the Assembly on June 18th, 1959. This resolution was referred by the Rules Committee to the Interim Committee on Finance and Insurance, and directed the committee to report to the Legislature by the seventh calendar day of the 1961 Regular Session a report relative to the subject of ". . . group insurance plans providing medical and hospital insurance coverage and their relations to the costs of hospital services and medical care in the State of California."

The chairman of the Interim Committee, the Honorable Thomas Rees, and I had a number of discussions with regard to the resolution, attempting to develop the most suitable program to answer the mandate of the Legislature to report on this subject matter. These planning sessions pointed out that there was a good deal of sentiment on the part

of the principals in the fields of prepaid hospital and medical care that there was no demonstrated need for a comprehensive study in this field, as pointed out in Finding Number 16 of the attached report. In light of this general feeling, the heavy load of interim committee work placed upon the members of this committee, and the financial limitations placed upon the committee during the 1959 session, the chairman and I agreed that I should proceed to do investigation as required by the resolution, and in the event that I was able to demonstrate a real need for a thorough investigation, we would then take the matter up in detail with the full committee and with the Rules Committee, to determine a course of action.

I made every effort to contact the major parties at interest with regard to the subject matter of the resolution, and in fact held meetings with board members of: the California Medical Association, the California Osteopathic Association, the California Hospital Association, the California Osteopathic Hospital Association, Blue Shield, Blue Cross, major insurance companies writing hospital and medical insurance in California, trustees of both negotiated and management health and welfare funds, and hundreds of interested citizens.

I soon found that the subject matter was taking all of my time, and that I was receiving dozens of unsolicited communications each week.

In order to facilitate the handling of all of the information and requests, and to develop a preliminary plan for studying the subject matter, I made arrangements with the University of California, approximately July 15th of 1960, to secure the services of Mr. Ted Ellsworth on a part-time basis. Mr. Ellsworth has an extensive background in this general field, and is currently Administrator of Public Programs, Institute of Industrial Relations, of the University of California at Los Angeles.

During the last four months both Mr. Ellsworth and I have spent substantially all of our time on this project. We have interviewed hundreds of persons, including patients, insureds, doctors, hospital administrators, nurses and other hospital personnel, officials of hospital and medical organizations, labor, management, and consultants in every related field. During this same four months period, I have handled in my office over 2,000 unsolicited letters from persons throughout the State who feel that this investigation represents one of the most important activities of the Legislature.

The attached preliminary report, in my judgment, demonstrates the need for a continued investigation and public hearings into the entire field of prepaid hospital and medical care, and I earnestly solicit your support of the preliminary program as outlined in the attached report.

Very truly yours,

RONALD BROOKS CAMERON

SECTION I

INTRODUCTION and BACKGROUND

The phenomenal growth of health insurance following the impetus given to labor-management funds during World War II and the Korean War because of the wage freeze and other factors has, in itself, been responsible for many of the problems that have been called to my attention. The headlong plunge into a relatively new field by parties with such diverse interests as life insurance companies, labor and management, the medical and hospital community, health service plans, and the consumer, was bound to create a conflict of interests that could only result in chaotic conditions. The lack of planning of any of these parties, a difference of opinion as to the purposes and aims of health insurance programs, and finally the failure of the vendors, and the buyers of health coverage to co-ordinate their programs in any way whatsoever, was bound to cause many of the troubles that have developed.

While this report does not intend to discuss the rapid growth of health insurance in detail, it should be noted that less than one-fourth of the population had health insurance prior to World War II, and that now over two-thirds of the population not only have some type of health insurance program, but that segments of the population are now being reached, and a broader coverage is being offered, than was thought possible even as recently as five years ago.

This new broad coverage, and coverage of heretofore uninsurable groups, along with a growing utilization of services and facilities, has resulted in an increase from 3.7 percent of the disposable dollar of consumer income going to medical care in 1946 to 5.3 percent in 1958.

Figures compiled by Governor Brown's Committee on the Study of Medical Aid and Health in California indicate that medical expenditures in 1959 were 111 percent of the 1939 Consumer's Price Index, and hospital expenditures were 329 percent of the 1939 Index.

A survey of the Consumer's Price Index illustrates how medical care costs have risen in comparison to the overall cost of living during this period of health insurance growth:

	1947	*1959*
All items	95.5	123.7
Medical care	94.9	148.6

The increase in medical care costs during this period was 50 percent greater than for all items. In addition to these increased costs on an overall national basis, hospital and medical costs in California are the highest in the United States, as will be shown by the following figures:

Medical Costs—1958—As Indicated by Medical Economics

	Los Angeles	*San Francisco*	*Average 8 selected cities*
General practitioners, office calls	$5.33	$5.00	$3.69
General practitioners, house calls	8.67	7.83	6.01
Surgeon's fees for:			
Appendectomy, excluding anesthesia	233.33	208.33	160.36
Tonsillectomy, excluding anesthesia	100.00	95.83	69.39
Tooth extraction	9.00	9.92	5.89

Costs—1958—As Compiled by Health Information Foundation

	Los Angeles	*New York*	*San Francisco*	*Scranton*
Obstetrics	$175.00	$166.17	$163.57	$78.50
Eyeglasses	30.83	15.95	30.92	----

The difference in hospital costs is even greater when it is considered that in 1958 the average daily cost for hospitalization in all general hospitals in the United States was $28.17, whereas the average in Los Angeles has been estimated at approximately $50.00.

The average nation-wide for a three bed ward room in 1958 was $15.91, Los Angeles was $21.50, and San Francisco was $23.12. When we consider further that from 1946-1958 the short term general daily hospital charges rose 258 percent and that the average cost per stay rose 225 percent, the seriousness of the problem can be seen. It is further estimated by authorities in the field that hospital costs in California will continue to increase at the rate of 5 percent to 10 percent per year.

This report does not represent a complete treatise on the rise in hospital and medical costs and their relationship to the increase in prepaid hospital and medical insurance coverage, but merely attempts to document briefly the need for investigation and some legislation.

It is not possible at this time to draw any positive conclusions with regard to the causes for the rapid increase in costs in the fields of medical care as illustrated above. Certainly a portion of the increases can be attributed to the general inflation from which the country has been suffering during the past decade, a portion is occasioned by the increased technology during this period, and a portion has been caused by the rapid increase in wage scales in the para-medical field, due to the extremely low base of wages in these fields during the past decade.

It is generally accepted that part of the increase has been because of the patient's ability to pay the increased fees through prepaid hospital and medical insurance. Certainly it is more than coincidental that the sharp increases in these costs parallel exactly the years of development of insurance in the hospital and medical field.

SECTION II

FINDINGS

1. Both individual and group prepaid hospital and medical insurance policies are being cancelled by some companies, and claims are being denied, for unexplained or highly questionable reasons, resulting in the insureds not having coverage at the time of greatest need.

2. There is such an array of choices available, by virtue of combinations of various benefits in both group and individual prepaid hospital and medical care policies, that it is currently impossible for the lay person to evaluate between available plans.
3. Exclusions of coverage in prepaid hospital and medical care insurance policies are frequently relegated to the fine print and often tend to be misleading.
4. Insurance law of the State of New York now requires that the purchaser may, at his option, cancel any prepaid medical care policy within the first ten (10) days of receipt of the policy and receive a full premium refund.
5. Some individual prepaid hospital and medical care policies sold in California return less than 10 percent in benefits on the premium dollar and some company loss ratios on all policies are less than 25 percent of the premiums earned.
6. Persons who have had group coverage of prepaid hospital and medical insurance frequently find that upon leaving the group they may not convert to individual coverage, or that the conversion premium is prohibitive, or that the benefits are so reduced as to render the coverage negligible.
7. A large number of persons are covered by more than one prepaid hospital and medical insurance policy; i.e., both husband and wife covering the entire family through group plans, which in some instances results in a financial gain to the insureds as a result of a claim being paid by more than one company.
8. Some trustees and welfare fund officials have expressed concern over the failure of the 1959 Legislature to renew the Rees-Doyle Act (a Reporting Act requiring the disclosure of certain financial information in reference to negotiated health and welfare funds).
9. Commercial insurance companies are currently regulated to some extent by the Insurance Commissioner of the State of California with regard to their rate and reserve requirements; however, nonprofit plans such as National Health Plan, Pacific Health Plan, the Kaiser Health Plan, and Blue Shield are not subject to the same regulations as their commercial competitors.
10. Due to a lack of planning on a regional basis there is currently, in some areas of California, a substantial overbuilding of general hospital beds. Of the medical care dollar, approximately 30 percent is spent for hospital benefits.
11. Currently the only basis for assuring medical care standards in California hospitals is through the voluntary action of each hospital to seek accreditation by the Joint Commission on Accreditation or the American Osteopathic Association accreditation program. Currently, 20.3 percent of the nonprofit hospitals and 79 percent of the proprietary hospitals in California have no supervision of the medical practices in the hospital, either through design, by not seeking accreditation, or because they are ineligible for such accreditation because of size, mixed MD and DO staff, physical limitations, and other contributing causes.

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12. Financial information with regard to both nonprofit and proprietary hospitals is not currently available, and the information that is available is not in such form that it may be compared hospital by hospital.
13. Most hospitals in California do not make available to the public a schedule of charges for normal services and goods provided by the hospital, other than the room rate. It is difficult to secure from most hospitals an itemized accounting of a given hospital bill.
14. Section 1416 of the Health and Safety Code reads as follows: "Information and records concerning any licensee or applicant received by the State Department under the provisions of this chapter shall not be disclosed except in a proceeding for the revocation, suspension or denial of an application for a license."
15. There are some hospitals in California that are operated by nonprofit corporations where the physical plant is owned by a profit-making organization and leased to the operating company. In some cases the annual net rental for the facility is more than 15 percent of the total cost of construction, land, and equipment. In other cases the lessor company reserves to itself the pharmacy, X-ray, and laboratory facilities and leases only the portions to the operating company which are traditionally operated at a loss.
16. There is an aura of distrust between the principals in the prepaid hospital and medical insurance field. Organized medicine, which in California represents approximately 75 percent of the practitioners, seems to recognize that most of the problems enumerated in Findings 1 through 15 do exist to some degree, but rejects the position that many of these shortcomings should be resolved by legislation. Their contention is that legislation would lead to a form of government intervention that, in their judgment, would be dilatory to the practice of medicine. The hospitals that belong to the voluntary association seem to concur in the judgment of organized medicine in the main; however, they recognize that immediate steps must be taken to curb many of these abuses. They are making a valiant effort through their associations, but admit that they have no control over the most flagrant violators. As a rule, these are not members of the California Hospital Association. The voluntary association includes only about 55 percent of the hospitals in the State.

Management from the insurance industry recognizes the shortcomings enumerated above, but is loath to move in support of any legislative program for fear of economic retaliation by some insurance companies who would not support the program, and by medical and hospital groups who would condemn the companies that might participate in such a program. Some negotiated labor-management hospital and medical insurance programs are critical of the insurance industry and organized medicine for not supporting a reform program. Other negotiated plans take the position of "why fight city hall."

This lack of rapport between the parties at interest makes it exceedingly difficult to ferret out the real problem areas which are causing an 8 percent per year increase in the cost of medical care while we are experiencing only a 3 percent annual inflation rate.

SECTION III

RECOMMENDATIONS

1. Consideration of legislation requiring that all prepaid hospital and medical insurance policies, after the policy has been in force for twenty-four (24) consecutive months, be noncancellable except for nonpayment of premiums, unless the carrier cancels all policies of the same class and type at the same time.
2. Legislation requiring the Insurance Commission, under the provisions of the Administrative Procedure Act, to establish a system of grading for all prepaid hospital and medical insurance policies, based upon the projected loss ratio of the policy, and requiring that all policies and related promotional material indicate clearly the grade of the policy and an explanation of the grading system.
3. Legislation requiring that all prepaid hospital and medical insurance policies list all exclusions with the listing of benefits, and that the exclusions be given equal prominence in a type of at least the same size and style as that with which the benefits are listed.
4. Consideration of legislation requiring that a full premium refund will be paid to the insured if the insured surrenders and requests cancellation of any prepaid hospital or hospital and medical insurance policy during the first ten (10) days after the receipt of said policy.
5. Consideration of legislation requiring the Insurance Commissioner, under the provision of the Administrative Procedure Act, to establish standards of minimum benefits, based upon loss ratios on policies that are sold in California. The Legislature, after public hearing, should set guide posts for the commissioner to follow.
6. Legislation requiring that upon leaving group coverage, conversion can be made without evidence of insurability (provided there has been coverage of the insured in the group for twenty-four (24 consecutive months). The converted coverage benefits shall be substantially the same as the group policy with no additional limitations or restrictions, and at a premium substantially the same as the group premium, giving consideration to the additional administrative expense of the carrier.
7. Consideration of legislation limiting the total benefit on hospital and medical insurance to the total of the economic loss to the insured. Legislation setting a formula for prorating of the liability where there is liability on the part of more than one carrier.
8. Consideration of legislation reinstating the provisions of the Rees-Doyle Disclosure Act, providing that duplicate copies of the federal disclosure form be filed with the Insurance Commissioner of California.
9. Legislation giving jurisdiction to the Insurance Commissioner over all groups selling hospital and medical insurance plans, and subjecting all competing organizations to the same requirements, with the exception of the gross premium tax.

10. Legislation requiring the State Department of Public Health to set up a master plan of hospitals for each geographic region in the State, with the help of a local planning council composed of physicians, hospital administrators, and the general public. Requirement that prior to the issuance of a license for the expansion of an existing hospital or building of a new hospital, that it shall be in conformity with the master plan. Only after public hearing and after the local planning council has made a recommendation that a variation from the master plan be authorized could a license be issued that is not in conformity with the master plan.
11. Legislation requiring the State Board of Medical Examiners and the State Board of Osteopathic Examiners to establish medical care standards for all hospitals after hearings as provided for in the Administrative Procedure Act. These standards would be supervised by the respective boards and violations of said standards would be reported to the State Department of Public Health. Any violation of such standards would be the occasion for an immediate investigation by the Department of Public Health and would occasion an action by the department for suspension or revocation of the hospital license.
12. Legislation requiring the State Department of Public Health to promulgate a uniform accounting system for all hospitals, similar to that promulgated by the American Hospital Association and the California Hospital Association. It would require that all hospitals adopt this accounting system by a specified date and that each hospital, subsequent to the adoption of the system by the hospital, be required to submit to the department at the end of each fiscal year, on a form provided by the department, such financial, operational, and ownership information as may be required by the department under rules promulgated by the department and as provided for in the Administrative Procedure Act.
13. Legislation requiring that each hospital licensed by the State of California establish its own schedule of charges for all services and goods normally provided by that hospital and that it file a copy of said schedule of charges, on a form provided by the State Department of Public Health, with the department by a specified date. The board of directors of each hospital could at any time amend its schedule of charges and said amended schedule would be effective thirty (30) days after the filing of a copy of the amended schedule with the department.
14. Legislation repealing Section 1416 of the Health and Safety Code.
15. Development of legislation to amend the nonprofit incorporation laws of California to preclude nonprofit operating companies being established to operate hospitals that are proprietary in intent.
16. Immediate creation of a subcommittee of the Finance and Insurance Committee to continue the study in the entire field of prepaid hospital and medical care with authority for the subcommittee investigation to run concurrently with the 1961 Legislative Session and the appropriation by the Rules Committee of sufficient funds for the subcommittee to maintain a full-time legislative consultant and a full-time legislative secretary.

SECTION IV

HEALTH INSURANCE

In reviewing the problems raised with health insurance, I found the main concern with individual policies as follows:

(a) High cost—especially for persons over 50 years of age.
(b) Restricted benefits that fail to meet any substantial part of the hospital or medical bill.
(c) Presence of pre-existing clauses that limit the value of programs to older persons.
(d) Cancellation of policies by the insurance company at a time they are most needed.
(e) Misrepresentation by insurance salesman.
(f) Complexity of policies which make them difficult for the buyer to evaluate.
(g) Concealment of exclusions and limitations by using small print and involved language which often is buried deep in the policy.

Since most of the problems in this field are caused by, or at least are partially due to, high insurance costs the following material extracted from the annual reports of the California Department of Insurance and other sources illustrates graphically the situation. Comparative figures of commercial insurance companies, Blue Cross, and Blue Shield indicate that on an average the expenses charged against the purchaser of insurance, or conversely, the benefits paid, are not substantially different insofar as group insurance is concerned.

The following table based on reports of the Health Insurance Council compares premiums earned to benefits paid:

TABLE No. I

Comparison of Loss Ratios Commercial Insurance Companies, Blue Cross and Blue Shield

(Figures in billions of dollars)

Insurance Companies—	*1957*	*1958*
Group premiums	$2,310	$2,160
Benefits paid	1,806	1,954
Ratio of benefits to premiums	–	93.5%
Individual premiums	1,379	1,484
Individual benefits	589	637
Individual ratio of benefits to premiums	–	48.4%
All policies ratio of benefits to premiums	–	66.7%
Blue Cross—Blue Shield—All Policies *—		
Premiums	1,919	2,141
Benefits	1,852	2,074
Loss ratio	–	97.4%
All Carriers—All Policies—Loss Ratio	–	90.3%

* These figures include group policies, individual direct sales policies, and conversions to individual policies from group policies. Estimates indicate that ratio of benefits to premiums is 94 percent group, 89 percent individual, and over 100 percent on group conversions.

However, the ratio of benefits paid to premium earned varies greatly both as to individual companies and as to type of coverage, as shown in Table II:

TABLE No. II

ALL HEALTH INSURANCE BUSINESS TRANSACTED IN CALIFORNIA

Comparison of Loss Ratios of Commercial Insurance Companies by Type of Coverage

	1955-58	*1958*
All business—health insurance	75.9%	79.0%
Group	86.4%	90.0%
Accident and health—individual	46.0%	44.9%
Noncancellable—individual	39.0%	40.5%
Hospital and medical—individual	45.0%	45.6%
All individual policy business	44.0%	44.6%

The following tables illustrate the wide variation within commercial companies as to the percentage of the premium dollar that is used to pay medical benefits. The group policy columns include all types of health insurance written by the various companies, including noncancellable policies, medical and hospital policies, income replacement policies, etc. The individual policy column includes only specific types of policies as identified in each table. The medical and hospital type of benefit is similar to, but usually not as extensive as, Blue Cross or Blue Shield policies:

TABLE No. III

Comparison of Loss Ratios of Group and Individual Health Insurance Policies of Commercial Insurance Companies

	1955-58		*1958*	
	Group (All health insurance)	*Individual (Medical and hospital)*	*Group (All health insurance)*	*Individual (Medical and hospital)*
	%	%	%	%
American National	70	36.1	133.1	39
Business Men's Assurance	65.8	45	63.3	43.2
Washington National	69.9	43.3	84.7	46.6
Mutual Life (New York)	99.1	-	109.3	24.5

TABLE No. III-A

	1955-58		*1958*	
	Group (All health insurance)	*Individual (Accident and health)*	*Group (All health insurance)*	*Individual (Accident and health)*
	%	%	%	%
Firemen's Fund	74.6	34.2	78.2	34.8
American Casualty	70.9	29.3	75	48.7
Continental Casualty	64.4	37.2	61.9	33.3
Ind. Ins. Co. of No. America	54.6	23.1	58.3	12.4

As can be seen from these figures, which include all the business of the carrier and not just that done in California, it is only occasionally that the individual companies will return as much as one-half of the amount in benefits to the individual policyholder as is returned to the group policyholder.

The following tables indicate the loss ratios for various companies that do a substantial California business:

TABLE No. IV

Loss Ratios of Group Health Insurance Policies Only

	1955-58 %	*1958* %
Independence Life	69	75.7
West Coast Life	76	80.9
Union Labor Life	84.5	87
Pacific National Life	74.9	77.7

TABLE No. V

Loss Ratios of Individual Medical and Hospital Policies Only

	1955-58 %	*1958* %
California Life	37.2	37.7
Pacific Mutual	37.8	42.6
Connecticut General	39.6	42.4
Provident Life and Accident	48.9	53.5
New York Life	39.7	45.5

All of the above figures are taken from statistics compiled for the Governor's committee.

While the four-year loss ratio average of all group business transacted in California is 75.9 percent, the range is very wide. At the bottom of the scale Industrial Life shows 5.3 percent, Fidelity Life and Income 14.4 percent, Manhattan Life 21.7 percent, National Casualty 54.8 percent. On the other hand, many of the companies averaged 80-95 percent.

Exhibit "A"

TABLE No. VI

Comparison of Financial Statements of Commercial Insurance Companies by Percentage Distribution of Premium Dollar for 1958

Hospital and Medical Individual Policies Only *

	Estimated premium	*Percent paid in benefits*	*Commission percentage*	*Percentage of total expenses including commissions*	*Dividends and gain for all health insurance business †*	
					Dividends	*Net gain*
Monarch Life	$2,754,557.37	44.5%	36.9%	65.5%	3.3%	5%
Westland Life	3,318,701.81	41.5	44.1	57.6	Nil	0.3
Beneficial Standard	13,587,559.74	42.4	16.3	47.9	1	9
Constitution Life	8,520,000.00	50	23	40.2	0.13	4.3

* The estimated operating expense factor for Blue Cross in 1957, for similar types of policies, was 5.3 percent in Northern California, 6.5 percent in Southern California.
† These figures are for all group and individual health insurance policies, and not a percentage of the estimated premium shown on this table.
NOTE: The percentages in this table will not always equal 100 percent, as dividends and profits are not now available for this type coverage in every case. In some cases, there may be a loss which is wholly or partially offset by investment income; or, as in the case of Constitution, the net gain for this type of policy was only 9 percent.
SOURCE: Annual financial statements—California State Department of Insurance for business done in entire United States.

SECTION V

INDIVIDUAL HEALTH INSURANCE

As far as individual policies are concerned, for all business written in the United States some companies show a four-year average of less than 25 percent. For hospital and medical policies some loss ratios were: Security Life and Accident 28.2 percent, North American Life 26.4 percent, Central Standard 29.8 percent, Indemnity Insurance Company of America 6.8 percent.

For accident and health, the figures were: Hearthstone 19.6 percent, Indemnity Insurance 23.1 percent, Protective Security 16.9 percent, Federal Life and Casualty 13 percent, Stuyvesant Life 3.5 percent.

For noncancellable, Continental Assurance showed 23.6 percent, National Life and Accident 16.7 percent, Union Mutual 18.2 percent, Massachusetts Casualty 12.4 percent, John Hancock 15.9 percent.

The amount of business transacted in California for these coverages was not secured.

1. *Noncancellable Policies*

With such a small amount of the premium dollar going to the policyholder in the way of benefits, the eventual result has been misrepresentation of policies, cancellations when coverage is most needed, overselling, refusal of coverage to many persons, and limitations and restrictions through health statements and pre-existing condition clauses that are usually misunderstood.

Complaints were received from persons who said that after holding a policy for many years, when suddenly taken sick they were quickly notified that the policy would be canceled on the next renewal date (the first of the following month).

I feel that only by legislation can these problems of high cost and misrepresentation be corrected. If a company is required to write only noncancellable types of health insurance, it is hoped that many of the misrepresentations made in the past will be eliminated. Therefore, an amendment to the Insurance Code is proposed. A summary of the proposed amendment follows:

Amendment to Sections 10350, 10350.2, and 10350.3, add Section 10350.13, and repeal Section 10369.9 of the Insurance Code:

a. All disability policies shall contain a provision that the insurer may not cancel the policy except for nonpayment of premiums, and that he cannot reserve the right to refuse renewal, providing that the policy has been in force for two years or more.
b. No renewal will be at increased premium rate unless premiums for all policies of the same class are increased.

Similar legislation has been adopted in New York.

2. *Classification of Insurance Policies*

One of the most frequent complaints that has been made by individual buyers of health insurance is that the policies and brochures of the insurance companies are so complex that the ordinary layman cannot evaluate one against the other. As a matter of fact, the high-pressure salesmen who sell many of these policies cannot themselves evaluate

them. A typical complaint is that the policyholder finds out for the first time of the conditions that are excluded when he files a claim.

One of the most flagrant cases involved a 69-year-old woman who had had a policy since 1956. In 1958 she was approached by a salesman for Westland Life Insurance Company who convinced her after a long sales talk that she should drop a policy of Constitution Life Insurance Company and take Westland which he alleged was much better and only slightly more expensive. In 1960 she was operated on for a hernia and her claim was refused on the ground that the condition had existed prior to taking out the policy. In reviewing this complaint, it was found that the policy was only slightly better and that the premium was much higher, but more important, her Constitution policy would have covered the operation and paid a total of about $400. Although a complaint has been filed with the Insurance Commissioner by her own doctor, who states that the condition was not pre-existing, the claim has not been paid.

This problem became of such great concern to the Governor's Committee that it has recommended gradation of policies. Its members generally agreed that the ratio of benefits to premiums paid and that the many misrepresentations that are being made in selling individual health insurance policies called for some type of legislation. It was felt that a classification or gradation of policies would be most effective, and study of methods of achieving this end are now under way.

In my own investigation I have come to the same conclusion as did the other members of the Governor's Committee. When the many different types of policies with their complicated restrictions and limitations, varying benefits, deductibles and coinsurance provisions, sliding scale for premiums by age of the buyer, noncancellable provisions, catastrophic coverage, technical language, and fine print, all complicated in some cases by high-pressure salesmen without a background in the health field and too often without any conscience whatsoever, the plight of the uninformed, indeed even of the informed, buyer becomes apparent.

Table No. VI highlights some of the causes of this problem. When it is considered that in some cases the share of the premium dollar which goes toward benefit payments is less than the salesman's commission, and that in most cases it is less than operating expenses, it is no wonder that there is widespread dissatisfaction with individual insurance policies.

The companies selected for this comparison are ones that have a substantial volume of business in California and against whom many of the complaints have been charged.

Table No. VI is attached hereto and marked Exhibit "A."

Two approaches to this problem are possible:

(1) Grading of policies by classifications "A," "B," "C," etc., in relation to the benefits paid, and

(2) Grading by the ratio of benefits paid to premiums earned.

The complexities of health insurance and the varying needs of different segments and groups of the population make it appear impractical to grade by benefit structure, and therefore I am recommending legislation based on the ratio of benefits paid to premiums earned.

The general recommendation will be that policies will be graded "A" if the company has paid in the previous year, or averaged over a five-year period, 75 percent claims ratio, "B" if between 65 and 75 percent, "C" if between 50 and 65 percent, and "D" if below 50 percent. For new companies a projected expense and commission schedule would have to be considered in grading the policies.

3. *Clear Statement of Policy Restrictions*

Since exclusions are usually delegated to a back page of insurance policies, it is suggested that all sales brochures, certificates, and policies list all exclusions with the listing of benefits, and that they be given equal prominence, in type of at least the same size and style as that with which benefits are listed. It is further recommended that exclusions be listed on the same page, and immediately following the benefit provisions.

4. *Free Examination Period for Policyholder*

It is now necessary in New York to give a person ten days after delivery of a policy to read and understand it. During this period he may cancel and secure a premium refund. One local insurance agent, Newell Larson of Torrance, California, advises that he uses this procedure in selling for the Provident Life and Accident Insurance Company. With the delivery of each policy, a letter is sent to the policyholder stating as follows:

> "Please take the time to read the policy and to understand what it will do when the need arises. Should there be any misunderstanding about the policy, or should you not be entirely satisfied with it, return the policy to us within 10 days of its receipt, and the premium you have paid will be cheerfully refunded."

Expressions received at a recent meeting of the Harbor Branch of the Insurance Underwriters' Association indicated that most of the agents felt that this requirement, as well as other items discussed in this part of this report, would help to solve the problem of misrepresentation and high-pressure salesmanship, as well as help to lessen the misunderstanding which is inherent in the sales of health insurance policies.

5. *Establishment of Minimum Benefits Provisions*

In order to avoid sales of policies which do not effectively provide any insurance, it has also been proposed that minimum benefit standards be set up by the Department of Insurance. Such a program has been in effect in California, but the minimums set are so low that they are not effective. For example, the minimum benefit that can be provided for a hospital room is $3 per day, whereas the charges for a three-bed ward room in both San Francisco and Los Angeles now averages well above $21 per day. At the same time, there appears to be no enforcement even of these minimal requirements.

It has been proposed that no policy could be written by any company unless at least 75 percent of the premium dollar goes into providing benefits.

Any of these proposals would tend to drive some of the marginal companies out of business, and to restrict the activities of the high-pressure salesman who will only sell if his potential earnings are high.

SECTION VI

GROUP HEALTH INSURANCE

Although it is true that most of the complaints which I received were regarding individual policies, many problems concerning group health insurance exist, and if the parties themselves do not solve them, they will soon become a matter of great concern.

The most frequent complaint of the group buyers was in regard to the continual rising cost of health insurance programs. There was little or no indication that insurance company costs play an important role in this respect. Except for the very small group buyers and the professional associations, insurance company expenses charged to the group account have varied between 4 percent and 10 percent of premium, and indeed insurance company spokesmen have complained that many companies have lost money on their group program operation in the past year. It must be pointed out, however, that when earnings from investments through use of the group buyers' money is taken into consideration, few losses have occurred.

Hundreds of reports filed under the Rees-Doyle disclosure provisions have been examined, and few would merit any real criticism of either the insurance carrier and its agents, or of the trustees of the funds.

Only one glaring case, concerning the Metropolitan Casualty Company (now out of the group health insurance field) and the Los Angeles Hotel and Restaurant Owners and Culinary Workers Fund, was noted. In this case, a 15 percent commission was paid to a broker in 1958, resulting in a payment of about $49,000 on a premium of slightly over $300,000. The usual commission on this type of case would be from 1 percent to 3 percent, probably not in excess of $5,000. In this instance the Trustees of the Fund disclaimed any responsibility through a letter to the Insurance Commissioner, pointing out that they knew nothing of this agreement, and that it had resulted only in loss for the company since the benefits paid had exceeded premiums earned.

Many complaints were received concerning unnecessary utilization of health programs, unnecessary medical care, hospitalization and surgery and the high cost of hospitalization. A few cases of fraud were indicated.

General complaints received have to do with unnecessary increases in insurance costs because of greater utilization, and higher charges for the insured population. The extent to which these conditions exist is disputed by the parties. That they do exist is not argued by any informed people as the following will show:

(a) The Administrator of the Motion Picture Health and Welfare Fund in 1956 issued a report indicating that by increasing benefits for the administration of anesthesia by 25 percent, its insured members realized only an 11 percent gain because of increased doctor's fees.

(b) The Health Insurance Council, in a survey for 1955, found the cost of medical care for a family to be $145 per year of insured, $62 if not insured.

(c) Increases because of major medical programs are quoted from many sides. The Medical Claims Bureau of Los Angeles reported charges of $1,000 for a hernia, $800 for a hysterectomy, $150 for a cystoscopy. Dr. Robert Kimbro, in Medical Economics, reported charges of $1,800 for removal of an eye, $1,000 for a thyroidectomy, and estimated that under major medical insurance, doctor's charges were 20 percent-25 percent higher than private patient fees. The *Wall Street Journal* reported Robert E. Ryan of Royal Liverpool Insurance Group, one of the early leaders in the major medical field, as saying, "The hypochondriacs really stung us."

(d) The Health Information Foundation, in a 1958 study, found utilization much higher among the insured as shown in Table No. VII:

TABLE No. VII

Comparison of Hospitalization for Insured and Uninsureds

	Insured	*Uninsured*
Percent of patients hospitalized each year	14%	9%
Average number of days in hospital each year	1	0.7
Percent of hospitalized patients that had surgery	9%	5%
Rate of appendectomies per 1,000 persons	11	5

(e) A survey by the Maryland State Medical Society among its own doctors showed the following:

TABLE No. VIII

Percent of doctors who believed that there were hospital admissions for the convenience of the doctor	58%
Percent who thought there were admissions for convenience of the patient	58%
Percent who thought there were prolonged or unnecessary hospitalizations because of insurance	61%
Percent who thought hospitals are used uneconomically	77%

(f) Some cases of fraud have been uncovered. Walter Ogden, M.D., of North Hollywood, California, has just been convicted of filing fraudulent claims against insurance companies. The Hollywood Citizen-News of November 15, 1960, reported that he had been convicted of three counts of violation of the insurance code, two of grand theft.

The Saturday Evening Post recently, in an exposure series, told of a company that decided to stop sending checks to the doctors but to send them instead to the patients. Shortly after sending an insured person a check for $200 for an appendectomy, it was returned with a note explaining that a small mole had been removed—not an appendix. In Los Angeles, some years ago, headlines told of the story of some 200 doctors who had defrauded their own health plan, Blue Shield, by filing claims for work never done. In a survey made for the San Francisco Labor Council in 1954, E. Richard Weinerman, M.D., of El Cerrito, California, estimated that 50 percent of the premium dollar went for expenses or unnecessary services.

(g) Jerome Pollack, program consultant for the Social Security Department of the United Auto Workers, AFL-CIO, in 1956 reported that a study of a U.A.W. program in which benefits were raised 26 percent yielded only a 9 percent gain to the worker because of increased medical fees.

(h) A study by the Michigan State Medical Society in 1958 revealed the following:

TABLE No. IX

Prolonged or Unnecessary Hospital Stays

Persons without any insurance	14%
Persons with commercial insurance (limited coverage)	30%
Persons with Blue Cross (comprehensive coverage)	36%

(i) A comparison of hospitalization under an insured Blue Shield plan, and the comprehensive Health Insurance Plan of Greater New York, illustrates reduced hospitalization where diagnosis and outpatient medical treatment are part of the program:

	Blue Shield	*H.I.P.*
Number surveyed	53,000	57,000
Annual hospital admission rate per 1,000	98.5	77.4

Despite some rather gloomy reports concerning the effects of group health insurance on medical costs, only minor legislation seems necessary in this field.

6. *Mandatory Conversion*

Since one of the most serious complaints concerning group policies is that they are often lost during times of disability and unemployment, just at a time when they are most needed, legislation is proposed in this respect.

Much discussion has been held indicating that there is a need for a return to "community rating" of insurance risks, instead of individual and group "experience" rating. I do not believe that this is feasible, or possible, at this time; however, a mandatory conversion program is feasible and would help alleviate this problem somewhat.

The State of New York passed such legislation in 1959, and despite some insurance company protests, it has not upset insurance company practices, as had been predicted.

While some companies offer a conversion program from group to an individual policy, they usually are drastically reduced in benefits, and increased in cost. Blue Cross and Blue Shield offer conversion programs in the hospital field which are substantially the same as many of their group policies.

SUMMARY OF RECOMMENDED LEGISLATION

I. Amendment to Section 10270.6 of the Insurance Code:

a. Group policy shall contain a provision that if an individual's group insurance protection is terminated for any reason whatsoever, and if he has been insured for 24 months he shall be entitled to have issued to him an individual insurance policy.
b. He shall not have to furnish evidence of insurability for either himself or his dependents.
c. There shall be no increase in premium, and the policy shall be noncancellable and right of renewal shall only be exercised for nonpayment of premium.
d. Benefits shall be substantially similar to those under the group policy.
e. The individual policy shall not exclude any conditions not excluded under the group policy.
f. The effective date shall be the date of termination under the group policy.

7. *Multiple Coverage*

One of the abuses of our health programs which leads to increased costs is that of multiple coverage. Doctors, hospital administrators, welfare fund administrators, and insurance agents cite many examples of prolonged or unnecessary treatment and hospitalization because of the profit that can be made by over-insurance.

One instance was cited in which a person insured under a group health insurance program realized over $2,400 in one year from hospital benefit payments, even though under another group program, Kaiser Health Plan, she had no hospital bill whatsoever to pay.

New York permits cancellation of a policy, in the public interest, where over-insurance exists, and where the policyholder has been notified in writing that he has exceeded the standards of insurance as determined by the State. Many companies are now beginning to write "duplication" clauses, and many group buyers are aware of the evils of this type of insurance. Many are, for example, reducing hospital room payments for those persons who receive Unemployment Compensation Disability benefits of $12 per day.

8. *Restoring of Rees-Doyle Legislation*

Another problem of group policyholders is that of having available to them information concerning the operations of other policyholders and insurance companies. Trustees are often unaware as to what administrative costs, expenses and commissions of insurance companies, and other operational costs are reasonable and customary.

In this connection, some trustees and welfare fund officials regret the failure to continue the disclosures and filings under the Rees-Doyle Act. Although few discrepancies were found, many felt that the information made available concerning insurance company practices and the experiences of other funds was of value.

The excessive commission paid by Metropolitan Casualty Company, in the case mentioned earlier in this report, was revealed to the trustees of the fund only when the insurance company filing was made necessary by the Rees-Doyle provisions. There can be little doubt that the spotlight put on companies and brokers prevented other such unreasonable charges.

Although similar information is on file in Washington, the expense of securing it when needed is almost insurmountable, except in the most serious cases. Several other funds, for example, found out for the first time that there were arrangements between the companies and agents and brokers, about which they had not known. The suggestion has been advanced that a duplicate copy of the federal reports be filed with the State Department of Insurance.

Conclusion

Although the costs of health insurance have increased greatly, and although the complaints regarding unnecessary expenses and over-utilization of insurance programs are widespread, I believe that the minimal legislation proposed can be effective, if it is accompanied by some regulation of professional services, as well as by continued self-policing by the carriers, welfare funds, doctors, and hospitals, all of which is taking place in varying degrees in some areas of the State, and by development of a program designed to educate the buying public as to the purposes of health insurance.

SECTION VII

NONPROFIT HEALTH PLANS

9. *Regulation of Nonprofit Health Plans*

The East Bay Welfare Council, AFL-CIO, the Marin and Santa Barbara Labor Councils, and others have passed in recent months, resolutions calling for state regulation of nonprofit welfare plans. These include Kaiser, National Health Plan, Pacific Health Plan, and others. The resolutions point out that there is no rate regulation of these plans. It reads as follows:

> WHEREAS, Hospital Service of California (Blue Cross), California Physicians Service (C.P.S.), and the Kaiser Foundation are allegedly nonprofit organizations operating for the public good in providing hospital service plans; and
>
> WHEREAS, Blue Cross, C.P.S. and the Kaiser Foundation have recently increased premium rates from 20 to 30 percent within the State of California; and
>
> WHEREAS, This action raises a serious question as to the so-called nonprofit operation of these hospital service plans; and
>
> *Now, therefore, be it resolved:* That the California State Federation of Labor introduce a bill at the next session of the State Legislature providing that no nonprofit hospital service plan shall enter into any contract with a subscriber unless and until it shall have filed with the California Department of Insurance a full schedule of rates to be paid by the subscribers to such contracts and shall have obtained the department's approval thereof. The department may refuse such approval if it finds that such rates are excessive, inadequate, or unfairly discriminatory.

Complaints have come to this committee which indicate that there is also a certain amount of misrepresentation, and in some cases, doubt as to whether or not some of the health plans can deliver what they promise. In 1959, the National Health Plan in Los Angeles contracted for hospitalization for a consumer group, but had no way of delivering such services. If there is dissatisfaction or a complaint concerning such a health plan policy; there does not exist any agency that has power to act and the buyer's only recourse is through legal action.

The creation of regulatory measures under the direction of the Insurance Department or the creation of a new Health Insurance-Health Plan Department has been suggested.

SECTION VIII

MEDICAL AND HOSPITAL COSTS

A more serious problem faces the State in regard to hospital and medical services, not only because of the unnecessary increase in the cost of medical care, but also because of a possible deterioration in some areas, and undermining of the confidence of the public, both in regard to health insurance programs and in regard to our medical practitioners and hospitals.

A great deal of publicity has been given to these problems in both the lay and public press, and response by dissatisfied patients after each

exposé is always so tremendous that I can only conclude that unrest regarding our medical system is widespread.

The extent of popular reading matter in this respect indicates the extent of, and contributes to, this unrest. At least four best sellers, which certainly lead to doubt concerning our entire medical system by the public, are Seymour Kern's "The Internes" and "The Golden Scalpel," Richard Carter's "The Doctor Business," and "It's Cheaper to Die" by William Michelfelder.

Newspaper stories have many filled columns. The famous Blum report has created public doubt as to the integrity of our hospitals. This study, made by Richard Blum, Ph.D., Stanford University, for the California Medical Association in 1958, was a study of the practices of 10 large hospitals. Very little has been released. However, the story of two surgeons having a fist fight over a patient on the operating table until one was floored, the story of the dying patient who was refused admission because a doctor did not like his Health Plan (supposedly Kaiser), and others of similar nature, caused James E. Smits, President of the Hospital Council of Southern California, to be quoted by the *Los Angeles Times,* on August 28, 1958, as follows: "I see no reason why the survey should be an indictment of the hospitals, as we have no control over the doctors." This has caused many in the field, and many patients, to wonder who does have control over the activities of doctors in the hospitals, if the hospitals themselves do not.

A 1959 series in the *Los Angeles Mirror News* stated that many doctors who charge $5 for an office visit raise their charge to $8 if the patient has insurance. It further stated that some doctors interviewed recognized these problems, and stated that organized medicine unwisely was always against any controls. It told of hospitals where the patient who enters with a broken toe may get a G.I. series, chest X-ray, urinalysis, EKG., or other unnecessary tests.

The *Los Angeles Mirror News* on October 13, 1959, quoted Leon Desimone, M.D., President of the Academy of General Practice in California, as stating, in response to this story, that the medical societies do what they can, but that the 5 percent of the doctors who consistently pad bills are not members of any society. Again, I question how controls can be effective as long as the voluntary method admittedly cannot touch the worst offenders, and the control of this minority group, whatever size it may be, is essential for the health and safety of the unwary public.

A series of stories, such as one about an award of $185,000 against Jack Magit, M.D., of the Beverly Hills Doctor's Hospital in a malpractice suit in which nonlicensed physicians were involved, further indicate the extent of the problem. It was charged in this case that unlicensed doctors were administering anesthesia at the hospital. As a result, the license of Dr. Magit to practice medicine was revoked in 1959, but this action has since been stayed by court action.

The revelation that a promoter convicted of a felony was involved as the owner of the Anaheim Memorial Hospital drew public attention there to our hospital licensing weakness. He later withdrew because of newspaper publicity which forced resignation of the medical staff. The *Anaheim Bulletin* of Friday, September 27, 1957, in writing of the resignation of the entire staff of 61 doctors said:

> "Although the physicians did not reveal the exact reason for their action, a check revealed that a prior criminal record of one of the members of the National Purchase Lease-Back firm may have prompted their action."

A lawsuit was filed in 1957 in Los Angeles against the board of directors of a Los Angeles hospital by a doctor who alleged that he was removed from the staff because he did not bring his "quota" of patients to the hospital.

Finally, the revelations of abortions, overcharging, and fraudulent insurance claims at Pacific View Hospital in Hermosa Beach, and the indictment of four doctors by the Los Angeles County Grand Jury, all tend to shake the confidence of the public.

These are just a few of the many stories that have been featured in the *Los Angeles* and *San Francisco Examiner,* the *San Francisco Chronicle, Time, Newsweek, Life, Look,* and other publications. Less sensational, but perhaps more frightening, are the stories that appear regularly in the professional journals, a few of which follow:

(a) Rollin Waterson, a medical economist for the C.M.A., stated at a union conference in San Francisco several years ago: "The more insurance coverage you buy, the more utilization you have, the more X-rays are taken, the more lab work is done . . . You say it has to stop and I agree with you."

(b) Lucius M. Johnson, M.D. referring in *Medical Economics* to a medical audit done in one of our better hospitals, said that 5 percent of the surgeons were doing work for which they were not qualified, and that another 5 percent were "scalpel happy."

(c) Paul R. Hawley, M.D., Director of the American College of Surgeons, was quoted by *Medical Economics* on July 6, 1959, as saying that 50 percent of our surgery is done by untrained surgeons and further that our health plans do nothing about quality of care. The *New York Times* further quoted him as saying: "Inadequately trained doctors were doing an increasing amount of surgery because every insured patient was a paying patient."

(d) The *Journal* of the American Medical Association of March 29, 1952, carried an article by Edward H. Daseler, M.D., which stated:

> "It is obvious to me, after practicing surgery in the Southwest for two years, that huge numbers of perfectly normal, undiseased inflamed organs, e.g. appendices, uteri, fallopian tubes, ovaries, and even gall bladders are being removed for one reason only: extirpation of the customary fee from the pocketbook of the unwary patient or his relatives."

With the growth of insurance coverage, and more money being available, these conditions have become worse and apparently will not be controlled until stricter hospital practices are enforced.

(e) An official report of the Medical Services Committee of the Los Angeles County Medical Association, in 1959, stated:

> "With the creation of these funds to provide a degree of protection against medical indigency, there developed in some physicians a subversion of motives wherein the welfare of the patient becomes secondary to the financial welfare of the physician . . . Our com-

mittee has so far received records which reveal the most flagrant abuses, overcharging, overuse, and fraudulent practices, but too often have felt frustrated in making adequate disposition of these cases due to lack of policy as formulated and approved by the council of this society."

Unfortunately, in Los Angeles there apparently still does not exist any effective policy. Indeed many insurance carriers and welfare fund officials consider it a needless waste of time to file a complaint with the Los Angeles County Medical Association regarding a complaint against any of its members. That this is also the experience of the general public is borne out by complaints from individuals which I have received, indicating that no attention has been paid to their protestations.

However, this is not the case in many areas of the State. In San Joaquin County and some 12 other counties, as well as in Long Beach, effective committees have been set up to review medical claims and complaints. The same is true insofar as the osteopathic, pediatric and optometric professions are concerned. Therefore, I believe that the Legislature should concern itself primarily with hospitals where the worst abuses occur, where cost variations have been most pronounced, and where doctors could be controlled through various hospital committees.

10. *Regional Planning*

The Governor's committee, his Advisory Hospital Council, and my own investigations all indicate that a lack of planning has resulted in too many beds in certain areas, and to installation of expensive equipment, which has inevitably led to abuse and high costs. Estimates of the cost to the public for this failure are admittedly guesswork, but one study in Michigan indicated that $5,000,000 a year is wasted in that state because of uneconomical hospitalization.

Ray Everett Brown, director of the Chicago clinics and hospital, and a past president of the American Hospital Association, estimates that an unoccupied bed costs about 80 percent of the amount that it costs to maintain an occupied bed. He further estimates that more bed-days were lost in 1958 because of nonoccupancy than were paid for by all Blue Cross plans. Mr. Brown advocates franchising of hospitals and stricter licensing through governmental action. Mr. Brown is not alone in his support and recognition of the need for tighter hospital controls in order to stop the upward spiral of hospital costs. Even those who do not agree as to method do agree that more effective control is necessary.

Annually a survey is carried out in co-ordinated action by the Califoria Hospital Association, local hospital councils, and the State Department of Public Health. Policies and planning criteria are revised each year by the Advisory Hospital Council. These criteria are used by the Department of Public Health in allocating state and federal funds. The state plan adopted for both the Los Angeles-Orange County and San Diego metropolitan areas pointed out that no hospitals of less than 150 beds should be built in either area. However, despite this, 90 general hospitals were built in Los Angeles from 1950-59 and all but 17 were under 150 beds. In San Diego, seven or eight new hospitals are

being planned, or are under construction. All are said to be under 70 beds. The advisory council's projection to 1975 for Los Angeles is that 160 new hospitals will be built, with all but 14 being under 100 beds.

It is apparent that there is a wide gap between voluntary public planning and the actuality of construction and operation of hospitals. Mr. Mark Berke, Director of the Mt. Zion Hospital and Medical Center in San Francisco, in a speech before the Western Association of Hospitals in 1958, pointed out the need for planning, although he hopes that it can be done on a voluntary basis:

> "We are rapidly approaching a time when it will no longer be economically feasible for each hospital to be an independent, self-sufficient enterprise, purchasing equipment for its own use without regards to the needs of the community.
>
> "In San Francisco, five hospitals are approved for open heart surgery, and others are planning to install this expensive equipment, even though three such installations would be sufficient. There are six electroencephalographs, although only one or two are fully used. Several hospitals are considering installing cobalt bomb units at a cost of $60,000 each, although only one is needed.
>
> "The planning of facilities on a co-ordinated basis is one of the most fertile areas for reduction of costs; but unfortunately it is one of the most difficult to achieve, involving as it does the autonomy of individual boards of directors, medical staffs, and hospital administrations, each with its vested interests, its own philosophy, and its own desires.
>
> "We must be prepared to consider objectively approaches to our problems which may involve the surrendering of some of our individual prerogatives, in order to insure the continuation of the whole."

I am in agreement with Mr. Berke's views. However, as far back as 1926, when the Hamilton Report, which dealt with the Los Angeles area, was issued, the importance of hospital planning was stressed. It did not work on a voluntary basis then for the very reasons stressed by Mr. Berke. I do not believe that it will work on a voluntary basis now, in view of the projections made by the Advisory Hospital Council, and the actual building that is now under way.

I have recognized and applauded the attempts of the California Hospital Association to improve the situation, but I do not believe that exposure will stop those who are promoters, or those doctors who need a hospital as a base of operations. Indeed, exposure alone may create an air of martyrdom which will prevent any real action against certain hospitals.

The combination of profit-making hospitals, unethical doctors, lack of planning, lack of standards, a shortage of accredited hospitals, and an oversupply of small hospitals, have all combined to make Los Angeles, and California, the highest-cost hospital area in the United States. The legislation that I have proposed is similar to recommendations which have been made by the Governor's Committee on the Study

of Medical Aid and Health, and to legislation which will probably be introduced by the California Hospital Association.

The basic difference in approach, however, is that the C.H.A. will probably support permissive legislation which calls for regional planning and public hearings, but with no power to enforce or regulate. It is based on the theory that exposure will accomplish the same results as mandatory legislation. However, C.H.A. may not recommend total exposure, and the necessity of filing annual financial statements and pricing schedules may not be called for. *It is my belief that exposure of hospital records, protecting, of course, the privacy of patient records, is necessary and will help to avert rate regulation which the C.H.A. believes will be detrimental.*

While the C.H.A. will probably oppose legislation with teeth in it, there are many hospital administrators and leaders who feel otherwise. In California, many hospital administrators have agreed that there is need for legislation such as I am proposing, but they cannot publicly support it because of the position of the C.H.A.

On the other hand, at a convention of the California Osteopathic Hospital Association at Santa Monica in October of this year, open support was given to this legislation. The type of legislation that I recommend is not original with me nor is it as undesired by all hospital people as might appear to be the case.

I have already mentioned that Ray Everett Brown, a recent past president of the American Hospital Association, and highly respected in his field, has long recommended the franchising of hospitals in order to reduce costs by better hospital planning. In response to a letter I wrote him regarding this proposed legislation, he stated that he believes that the controls relating to construction and expansion of hospitals in California are necessary and that full public disclosure is, of course, a good thing.

Another well-known leader who is not fearful of hospital regulation is William J. McWilliams, an attorney, and president of Arundel General Hospital in Annapolis, Maryland. "Trustee," the Journal for Hospital Governing Boards, printed a speech he delivered early this year during National Hospital Week. In it, he proposed a program that included:

> "The regulation of hospital rates by the Public Service Commission. . . . In time the commission would develop uniform accounting procedures, etc.
>
> "The co-ordination and control of expansion and new construction by the Hospital Council of Maryland. . . . We must be sure that there are not too many hospitals; that they are not larger or more costly than they need be; that there is no wasteful duplication of services, and that all building programs have economic justification. . . . It should have the power to veto any building program of which it does not approve."

Complete disregard for the community desires and needs is illustrated in the case of the Martin Luther Hospital in Anaheim, California. Despite protests from some segments of the community, in

which there are now many unoccupied beds (hospitals in the area are running 60 percent to 70 percent occupancy), the investors went ahead with the building. A nonprofit corporation which will pay excessive rent, approximately $500,000 a year, to the investors has been established by two small Lutheran churches in the area. I am keeping in touch with this situation, as it is rumored that there may be a fund raising drive in the community, and any such effort will be opposed by community leaders with whom I have met.

An even more flagrant case, illustrating the failure of the voluntary exposure approach involves the town of Ojai, where a hospital district was proposed, and before financing could be secured a doctor from Los Angeles, Frederick Gruneck, moved in and announced plans to build a 25-bed hospital. This, of course, would have ended any chance of obtaining governmental funds for construction of the district hospital.

The mayor and other officials, as well as a majority of the doctors, were opposed to the proprietary hospital.

Ads were taken in the *Ojai Valley News* in September, 1958, by a citizens committee, which asked: "Do we want a district nonprofit hospital or one like Northridge?" They then went on to reveal the profits made by Dr. Gruneck out of the operation and sale of the Northridge Hospital in the San Fernando Valley.

Two town meetings were held. At the second one, Mr. Charles Abbott, Executive Director of Blue Cross, spoke and quoted Gordon Cumming, Chief of the Bureau of Hospitals, as being opposed to the building of a hospital in Ojai at the time. The *Ojai Valley News* of Thursday, December 11, 1958, said in relation to Abbott's talk with Cumming:

> "Cumming said that . . . residents should not consider building a hospital until the area could afford at least a 50-bed hospital, as an institution must be at least that size to afford the expensive equipment used in modern medical research."

It went on to say:

> "Abbott said 'generally speaking, our experience is far better with nonprofit hospitals.' He said his office deals with 115 nonprofit and 135 proprietary hospitals in California."

On the same program, Louis Quinn, Managing Director of the California Forward Fund, and Henry Niebanck, a member of the Board of Directors of the California Hospital, both spoke in favor of nonprofit operations.

Despite the obvious desire of the townspeople to develop their district nonprofit hospital, it was only a short while after this meeting that the wishes of the townspeople were ignored, and Dr. Frederick Gruneck, owner of two highly profitable proprietary hospitals in Los Angeles, began construction of a hospital. Even though every form of exposure was used, including help from Blue Cross, the Chief of the Bureau of Hospitals, and other well-known people in the field, the efforts failed as there was no way in which the hospital building could be stopped.

A summary of the portion of a recommended bill dealing with regional hospital planning is as follows:

AMENDMENT TO HEALTH AND SAFETY CODE

431.2. Advisory council of eight appointed by Governor. Also a director of Hospital Advisory Council. Representatives of groups, state agencies, and consumers with knowledge of hospitals.

431.5. Health department may establish hospital regions after consultation with advisory council.

431.6. Department shall appoint regional councils. Director and 12. Three physicians, three hospital administrators, six labor, prepayment plans, and industry.

431.7. Regional councils shall develop regional plan for hospital expansion in consultation with health department. In doing so, shall review utilization, develop standards of community need, and conduct public meetings.

431.8. The department shall develop and bring up to date annually regional plans.

431.9. If advised by department that a proposed new hospital or expansion is in conflict with regional plans, the regional council shall conduct public hearings.

SECTION 1. 1402. Applicants must file information concerning ownership, type of facility, and must be of reputable character, and must present evidence of ability to comply with the regulations of the department.

(h) Must present evidence of need for facility.

(i) Must file change of ownership information.

1402.1. Department shall determine if hospital is in compliance with regional plan. May not issue license if in conflict until proposal considered in public meeting by regional council. Department cannot issue license for a proposed new hospital that is not in conformity with regional plan without the affirmative recommendation of the regional hospital council.

1402.5. Requires approval of state department for expansion of an existing hospital.

11. *Medical Standards for Hospitals*

Hospital planning is not the only area in which legislation is needed. Medical service standards must be made mandatory for all hospitals, not just for those that voluntarily seek accreditation. The need for tighter regulation can best be seen by the following reports:

(a) Medical Economics, 1960, quoted the American College of Pathologists as warning doctors that 78 percent of the hospitals of under 100 beds had inadequate laboratory supervision.

(b) Dr. Kenneth E. Babcock, Director of the Joint Commission on Accreditation of Hospitals, reported that last year 1,000 out of 4,000 major hospitals inspected failed to meet standards of good hospitalization. During the year, 223 accredited hospitals had taken a turn for the worse. Of the 1,000 mentioned, 400 were refused accreditation, 600 put on probation. In addition, there were 3,000 hospitals that were not

accredited or that were under 25 beds and were not inspected. Dr. Babcock goes on to report that in one hospital 600 out of every 1,000 operations were abortions. In another, there was removal of 380 uteri, of which 300 were unnecessary. James C. Doyle, M.D., Assistant Professor of Gynecology at the University of Southern California, earlier made a similar study of hysterectomies performed in Southern California hospitals, with similar results.

(c) A 1960 study by the American College of Surgeons in 24 top grade midwestern hospitals indicates that there is 24 percent overuse of antibiotics in hernia surgery. One thousand five hundred thirty-six hernias were performed. Five hundred sixty-nine should not have needed antibiotics. Of this number 421 received them, however. It was estimated that this unnecessary use of antibiotics added $44.50 per stay for each patient, as well as being harmful, in some cases, to the patient. While it is true that the Joint Board of Accreditation does a conscientious job of trying to elevate standards, it has no control over almost one-half of the hospitals in the United States. *Since its actions are voluntary, those who want to practice in an unethical way continue to do so.*

In California the situation is worse than in the country as a whole, as is shown by Table No. X.

TABLE No. X

Percentage of Accredited Hospitals in California

Type of hospital	*Number*	*Percent accredited*
State	2	100
City-County	51	52.9
District	48	35.4
Nonprofit	181	70.7
Proprietary	161	21

The concern of labor in this respect led to the appointment of a hospital committee by the Los Angeles County Federation of Labor, AFL-CIO, to study the entire problem in 1958. This concern also resulted in resolutions adopted unanimously at the last statewide convention of the AFL-CIO which called for stricter regulation of hospitals.

In a report to the Federation, the committee told of a case at a North Hollywood hospital which it had visited because of a complaint from the Teamster's Union. A charge of $167.52 for three days hospitalization for an ingrowing toenail was reported. The average daily charge in this hospital was admitted to be $55-$57.

The owner of the hospital, an M.D., admitted that this was an unreasonable charge, and that this was the type of surgery he would do in his own office. He further stated that the reason for the high cost was that the surgeon had used the operating room for one and a half hours and had ordered unnecessary supplies and drugs.

When asked why the hospital did not deny such doctors staff privileges, he stated that they would merely go to another hospital, and his occupancy would drop.

Other items in the report were:

(1) poor hospital planning had led to chaotic conditions.
(2) many profit-making hospitals met no standards at all.
(3) that since there were no uniform accounting methods hospital charges varied greatly, and that the average hospital charges for

a tonsillectomy in Los Angeles varied from about $44 to $150 per case.

(4) that kickbacks were made to doctors by some hospitals.

When it is recognized that 29.3 percent of our nonprofit hospitals and 79 percent of our proprietary hospitals are not accredited, and that projections indicate we will continue to have more of the small hospitals which are usually proprietary and generally not interested in accreditation, the need for legislation to enforce the decent standards of the accredited hospitals can be readily seen.

Additional recommended amendment to the Health and Safety Code:

1411.5. State Department shall adopt medical practice standards established by State Boards of Medical and Osteopathic Examiners. Boards shall investigate medical practices and report violations to State Department.

Other types of legislation, and other proposals, have been suggested as a means of controlling hospital practices.

(a) Mr. George Shecter, formerly Administrator of the American Hospital, has proposed that every hospital have a licensed physician or surgeon on duty 24 hours a day, and that an independent pathologist review all tissue slides. His recommendations are concurred with by Richard Blum, mentioned earlier in this report. In hospitals surveyed in Southern California, only 36 out of 84 proprietary hospitals have a doctor on duty 24 hours a day, while in the nonprofit hospitals 35 out of 69 have doctors 24 hours a day.

The December 25, 1954 issue of The Journal of the American Medical Association carried an article by Drs. Myers and Stephenson which stated:

> "Not all surgical tissues are diagnosed honestly. Some surgeons are reluctant to accept 'normal tissue' as an accurate diagnosis. Some pathologists are coerced into attempting to report some pathological process in every specimen. Some physicians are unwilling to criticize the surgery of a colleague. The decisions of the tissue committee are sometimes not recorded properly, making it difficult or impossible to evaluate the surgery later."

If these difficulties exist in accredited hospitals, surely conditions are even worse in nonaccredited ones.

(b) Richard Blum, Ph.D., mentioned earlier in this report, has stated that hospitals should make minutes of their staff meetings available to the public, and that a lay person should be invited to sit in as an observer on committee meetings. He also proposes that there be an accreditation system which would be operated by a State agency, with renewal each year of the accreditation status. Any doctor found to violate hospital rules would be put on probation for at least six months, and his work would be reviewed continually. If at that time there was no improvement, then his work would be restricted, and he could be reinstated only with approval of the accreditation team. Small hospitals, he believes, should be limited to emergency work, diagnostic procedures, and minor operations.

He estimated that inasmuch as 2 percent to 2½ percent of all physicians are psychopathic, chronic alcoholics, or narcotic addicts, they

should not be allowed to practice in any hospital until examined by a psychiatrist. The same should hold true of nurses and other employees who have any contact with patients. Also, he proposes that medical schools should improve instruction, insofar as the responsibility of the doctor to the hospital is concerned, and that medical students should be allowed to sit in with hospital committees, especially tissue committees.

(c) The National Health Federation, the Patients Aid Society, The American Patients Association, and the American Natural Hygiene Society, organizations with limited financing but who have large numbers of lay persons supporting them, all have recommended strongly that every hospital be required by law to have an independent pathologist review all tissue slides, and that patients' medical records be microfilmed and made available to the patient or his representative. One of the most frequent complaints received has been in regard to the inability of patients to secure their own medical records, although they appear to be made readily available for everyone else, including insurance personnel.

(d) Central medical records: Bertram R. Bernheim, M.D., Associate Professor of Surgery at Johns Hopkins believes that all medical records should be centrally kept, and subject to review by a medical audit. He stated, in a recent article, as follows:

> "In other words, society has certain rights, and one of them is to know exactly what is going on in our hospitals. Society goes to considerable lengths to supervise its banks, even, indeed, to having the Federal Government insure funds deposited therein. Why shouldn't it go to similar lengths with regard to hospitals? Is life of less importance than money?"

12 and 13. *Hospital Financial Reports and Schedule of Charges*

Hospital accounting: One of the major complaints against hospitals has been the impossibility of securing an accounting from a hospital, which is understandable in view of the patient's reaction to a very high hospital bill. This is not a new complaint. Several years ago the Health Plan Consultant's Committee, AFL-CIO, submitted a bill of particulars to the Hospital Council of Southern California showing variations of as much as 300 percent for identical items.

As a result of this, and other complaints, the Hospital Council did adopt a series of regulations known as the Guiding Principles of Hospital Administration. In effect, this provided for uniform accounting and pricing methods.

A survey which I studied recently shows that there is still a wide variation of charges. In the Long Beach area charges varied for the same procedure or item, in similar types of hospitals, from 25 percent to 100 percent or more in many cases.

It must be conceded that the Hospital Council is making a valiant effort to enforce the Guiding Principles. Complaints are being received and heard promptly, and adjustments are being made.

However, there are weak links that seem to make legislation in this area important. In one instance, a welfare fund complained about a hospital's procedure, was upheld by the Council, but the hospital con-

cerned, the Valley Hospital in Van Nuys, promptly refused to abide by the Council's decision and took the patient to small claims court.

Some 50 hospitals in Los Angeles and San Diego, who had subscribed to the Guiding Principles, were recently visited to determine if the charging schedules were readily available. In most cases, the clerks either knew nothing about the Guiding Principles, referred the investigators to the Hospital Council, and in only two cases did they make the schedules available. This program, effective July 1, 1959, has improved the situation somewhat, but still has not made the pricing methods of hospitals easily accessible or understandable to the public. Then, of course, as in the case of accreditation, we find that most of the worst hospitals either do not subscribe to the Guiding Principles, or pay no attention to them.

In addition to the problems of enforcement there are those caused by the preponderance of hospitals run solely for profit. These hospitals, in many cases, will not go along with accreditation, the Guiding Principles, or any other self-policing methods that hospitals adopt. A few examples of the profits which can be made follow:

(a) *Modern Hospital,* in an article concerning excess profits in Southern California hospitals, reported that one hospital in Los Angeles made a profit of $10 a day per bed, and that in two years of operation it was able to completely pay for its initial cost.

(b) A Culver City Hospital report which I was able to see showed a net income in one quarter of $41,115, with a gross income of only $265,300.

(c) A brochure for Morningside Hospital in Los Angeles, 86 beds, indicated a projected income of $1,084,136, on which the net profit would be projected at $129,888. The total cost was estimated at $900,000, of which the investors reportedly put up $300,000.

(d) A sales brochure for Bon Aire Hospital, 39 beds, indicated an estimated projected annual profit of $91,500. The value of the hospital is estimated at about $400,000. Operating profit would pay for the hospital in less than five years. This brochure was prepared by the American Hospital Management Corporation.

Additional recommended amendment to the Health and Safety Code:

1406.7 Annual report of operations must be filed with department.
(b) Each hospital shall make public its schedule of charges.
(c) Annual reports to be available to public.
(d) Department may investigate complaints.

1411.1 State department, after consultation with advisory board, may make reasonable regulations, including standards of safety, facilities and equipment. May prescribe standards for determining public necessity. May prescribe uniform standards of accounting and reporting.

14. *Information Concerning Hospital Applications*

As indicated in the findings that I have presented, the restrictions imposed by Section 1416 of the Health and Safety Code impede any effective investigation of hospital practices and their effect on health

insurance costs, and I therefore recommend repeal of this section so that all the facts concerning our hospitals can be made known.

15. *Closer Investigation of "Nonprofit" Hospitals*

Many indications exist that some "nonprofit" hospitals become very profitable. This is achieved by excessive rent and interest provisions, and leasing out of the profit-making aspects of a hospital, namely laboratory, X-ray, and pharmacy. Several examples of this are:

(a) William Henderson, who in 1959 published a hospital rate manual, stated that Northridge Hospital often profited as much as $45 per patient day, and that the average charge was $70. A published report showed that this hospital sold out to a nonprofit corporation with a profit of $127,000 on an investment of about $500,000, and contracted for the owner to serve as "administrator" for $1,000 a month for 12 years, and as a consultant for the next 10 years at $900 a month. Dr. Frederick Gruneck, the owner, is about 60 years of age, and in the event of death the entire contract is to be paid to his estate.

An ad in the *Ojai Valley News* of September 4, 1958, in relation to this hospital, was headed: "Disclose Profits of 'Nonprofit' Hospital." It stated that the owners of the land, of which Dr. Gruneck was the majority stockholder, netted a profit of $217,435 (200 percent) on the sale to the nonprofit foundation, and that Dr. Gruneck's contract as administrator and consultant over a 20-year period would net him $252,000, which would be paid even if he died the first year.

A report from Dun & Bradstreet, Inc., of September 12, 1958, indicates that the foundation has leased the hospital pharmacy and gift shop to a corporation headed by Dr. Gruneck. At that time, its volume of business was $130,000 per month.

(b) A brochure for Anaheim Memorial Hospital indicated a projected income of $1,092,018. It is reported that $500,000 cash was put up by the investors. In five years they will have recovered their investment, and paid off a large part of the loans made to buy the land and build the hospital. This is supposedly a nonprofit operation.

It is for these reasons that I believe our most serious problem is that of the hospital, and that no voluntary approach can solve all the problems of the unethical hospital operators, and that mere exposure cannot serve the purpose. As long as voluntary methods permit the operation of hospitals, no matter how few in number, which are not in the public interest and which endanger public health and safety, I believe that legislation, as proposed in this report, is necessary.

PREPAID HEALTH PLANS

It might be said that the Finance and Insurance Committee's investigation of the nature, status, extent and *modus operandi* of direct service, prepaid health plans began in earnest when Assemblyman Ronald Brooks Cameron reported on his one-man subcommittee's study of health insurance on December 5, 1960. He disclosed:

> Complaints have come to this committee which indicate that there is . . . a certain amount of misrepresentation, and in some cases, doubt as to whether or not some of the health plans can deliver what they promise. In 1959, the National Health Plan in Los Angeles contracted for hospitalization for a consumer group, but had no way of delivering such services. If there is dissatisfaction or a complaint concerning such a health plan policy there does not exist any agency that has power to act and the buyer's only recourse is through legal action.[1]

Mr. Cameron noted that there was some sentiment for placing health plans under the jurisdiction of either the Department of Insurance or a new government agency.

Three months after the Cameron report was made public, freshman Assemblyman John T. Knox introduced Assembly Bill 2083. A causal connection between these two events should not be inferred as the purpose of the Knox bill lay in another direction.[2] A.B. 2083, in substance, would have required every nonprofit organization whose purpose is to distribute the cost of health services by means of aleatory contracts to file various schedules of rates and services with the Insurance Commissioner *for his approval.* The bill specified that the commissioner should not approve any rates which he found to be excessive or discriminatory.[3] A.B. 2083 was considered and discussed in several hearings of the Health Insurance Subcommittee and finally, because of vigorous opposition, was set aside for interim study.

This measure, then, in addition to the Cameron report, laid the foundation for a thorough inquiry into health plans in the 1961-1962 interim.

Before discussing the findings of that investigation, however, some attention should be given to the history of health plans, their role in voluntary coverage today and their legal position.

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[1] *Assembly Interim Committee Reports*, Vol. 15, No. 24 (1960) p. 118.

[2] The precursor of the Knox proposal was Senate Bill 100 (Randolph Collier) of the 1959 Regular Session. The Collier bill failed to win the approval of the Senate Committee on Insurance and Financial Institutions.

[3] These tests are apparently borrowed from the McBride-Grunsky Act (Insurance Code §§1850-1860.3) which governs the rates of insurers. This act modifies "discriminatory" by preceding it with "unfairly" and also adds the criterion of "unreasonable" (i.e., too low).

I. The Growth of Health Plans in California [4]

Healing is a matter of time, but it is
sometimes also a matter of opportunity
:HIPPOCRATES

The origin of prepaid health plans in California has been traced back as far as a century ago when fraternal organizations, assorted nationality groups and certain labor unions promoted burial societies to meet mortuary expenses. The validity of cost-spreading as a principle to be applied to the recurring financial burdens of medical care gradually became apparent over the decades and this prompted the burial societies to add sickness benefits.

One of the oldest health plans still in existence is the French Hospital Association *(Societe Francaise de Bienfaisance Mutuelle de Los Angeles)* which was founded in 1860 as a "mutually benevolent, protective association" and built its first hospital in 1869.[5]

Impetus to development of medical and hospitalization indemnification arrangements has been attributed to the enactment, in 1911, of the Workmen's Compensation Act. And during the Progressive Era the Legislature, acting in concert with Governor Hiram Johnson, adopted and referred to the electorate a constitutional amendment to establish a system of state medicine to be financed through taxation. It was rejected in the 1918 election.

Although growth during this period was markedly gradual, by 1930, excluding railroad workers, nearly 50,000 employees were participating in group plans by which they secured medical service for *non-industrial injuries* and ordinary illness in return for payroll deductions.[6] According to Murray Klutch:

> These figures excluded perhaps an equal number of persons covered by the steam railroads of this State. Out of a total population of 5.7 million in 1930, of whom approximately 2.4 million were gainfully employed, an estimated minuscule of 100,000 persons in California therefore had some form of prepaid health coverage.[7]

1930, then, provides a useful "bench mark" by which to measure progress in health plan development for, as opposed to the hesitant growth in the first 70 years, health plans have fairly burgeoned since the Great Depression. As Mr. Klutch observes,

> . . . the unemployment and wage reductions of the thirties, the clamor for compulsory health insurance, and the awakening realization by the medical profession that the costs of medical care could no longer be met solely through the provision of charitable services or reduced fees led to the wide recognition that new methods had to be found to finance the costs of medical care. This unrest and acceptance of social change gave rise to the development in the late thirties and early forties of hospital and surgical prepayment programs sponsored by hospital associations and state and county medical societies.[8]

The Hospital Service of California (Blue Cross) was spawned in 1936 through the leadership of the Alameda County Medical Society. The Kaiser

[4] This section leans very heavily on a paper delivered by Murray Klutch, Director of Research for the California Medical Association, at the Conference on Regulation of Prepaid Health Plans at the University of California, Los Angeles, on November 29, 1962. The Committee is greatly indebted to Mr. Klutch for permission to quote from his paper extensively.
[5] Letter from Ronald J. Davey, administrator, to Assemblyman Rees, May 11, 1962.
[6] Pierce Williams, *The Purchase of Medical Care Through Fixed Periodic Payment* (New York, 1932) p. 94.
[7] Op. cit.
[8] Op. cit.

Foundation Health Plan may be said to have gotten underway in earnest in 1938 when the Kaiser organization, which had established an *ad hoc* medical facility while building an aqueduct in the California desert early in the thirties, undertook the construction of Grand Coulee Dam in Washington. The first Blue Shield plan in America was launched in February 1939 by the California Medical Association when it established California Physicians' Service.[9] The precursor of subsequent forms of medical groups was Ross-Loos which was formed in 1929.

During the war years of the forties, when ceilings were imposed by the federal government on price and wage increases, labor conceived the idea of pressing for "fringe benefits" in contracts with managements. Thus, the now-extensive health and welfare funds were born and they constitute today a significant share of health plans in existence. As a side note it may be observed here that the spurt of medical- and management-inspired plans in the late thirties, capped by the emergence of health and welfare plans produced through collective bargaining largely inspired Governor Earl Warren's advocacy, in the postwar period, of a comprehensive prepaid health program for *all* Californians.[10] Although Governor Warren's proposal failed, it produced the byproduct of an Unemployment Compensation-Disability program[11] (disability insurance) which plays a major role today by covering roughly 4,000,000 employees. The UCD program has been cited as a major reason for the fact that the percentage of Californians covered by Blue Cross health insurance and the assorted plans falls short of the national percentage.

A fairly recent phenomenon (i.e., in the past six years or so) has been the emergence of health plans which have been primarily concerned with selling to the public-at-large through advertising in mass media and house-to-house canvassing which the older plans have not found necessary. This type of plan evidently has capitalized on the widespread discussion of health insurance for the aged which has been in the forum of public debate since the passage by Congress of the Kerr-Mills Act and the drive to enact President Kennedy's "medicare" program.

II. Health Plan Coverage Today

According to the most recent and authoritative survey of health plans in California—that of the California Medical Association[12]—the number of persons covered by some type of health service (i.e., Blue Cross, California Physicians' Service, and "miscellaneous plans") lies somewhere between 4,000,000 and 4,250,000. Insurance companies, on the other hand, provide coverage for roughly 6,500,000 Californians. Since Blue Cross (i.e., the Hospital Service of California and the Hospital Service of Southern California) is technically insurance,[13] however, and since this report does not deal with insurers, Blue Cross' estimated 2,090,000 insureds should be added to the insurance category, thereby reducing the larger figure for health service-covered Californians to 2,160,000. *Keeping in mind that these figures are approximations,* the percentage of the population covered by health plans today would be 13.7.

[9] The unveiling of Blue Cross and Blue Shield in this period quite likely has some connection with the strong, though losing, vote given in 1936 to a proposition similar to that of 1918.

[10] It has been frequently noted that one defect in employee-oriented plans is the tendency to isolate from coverage persons not in the labor market (e.g., retired persons who have never enjoyed coverage).

[11] UCD provides benefits for sickness and injuries sustained by the unemployed as well as indemnification for wage loss.

[12] Bureau of Research and Planning, California Medical Association, *A Study of the Financing and Provision of Medical Care in California* (San Francisco, 1962), p. 3.

[13] Insurance Code §§11491-11517.

The great bulk of people enrolled in health plans or insured by disability carriers obtain their coverage through group plans—and these by virtue of their employment. A study made by the Division of Labor Statistics and Research, Department of Industrial Relations of 200 group plans in 1957 provides one index to the major carriers.

CARRIER/PLAN	PERCENT OF EMPLOYEES
Insurance companies	65
Blue Cross	16
Kaiser Foundation Health Plan	13
California Physicians' Service	2
Blue Cross and C.P.S. jointly	1
Direct payment or partial payment by plan	1
Other combinations of carriers	2
	100

Since the preceding survey only covers workers whose plans stem from collective bargaining agreements, it would be erroneous to assume the same breakdown would obtain for other employees. For example, proportions of State employees' options, as of January 1, 1962, were: [14]

CARRIER/PLAN	PERCENT OF EMPLOYEES
Insurance companies	33.6
California State Employees' Assn.—CPS	31.1
Kaiser Foundation Health Plan	14.6
Blue Cross—CPS	13.2
Ross-Loos Medical Group	1.6
Physicians and Surgeons Assn.	1.3
Foundations	1.1
Other	3.5
	100

While it is not complete, the list of existing plans appearing in the CMA Report is the most comprehensive extant. Among the 53 plans are sprinkled the names of many evincing a union coloration (e.g., Amalgamated Meat Cutters and Butcher Workmen, Local 563; ILGWU Panel Plan; Teamsters Local 94 Health and Welfare Plan) illustrating CMA's conclusion that "The most common method by which these plans are financed is through Health and Welfare Funds."

> Confusion can easily arise as to the primary source of funds used to finance these benefits. It might be interpreted as coming from the employer; however, since collective bargaining has been centered in fringe benefits in recent years in lieu of wages, it might also be considered as an employee contribution.[15]

Be that as it may, of the 40 plans responding to CMA's query, it is definitely established that in 20 percent of the plans the major financial contribution comes from the individual member. If the contention of labor is accepted and the welfare fund plans are thrown in, the percentage of "member as major source of financing" goes up to 60.

To summarize: 13.7 percent of Californians are covered by health plans; the vast majority are members of a group arrangement; the preponderance of group plans are established on the basis of employment (and usually constitute a "fringe benefit" of the job); and in most cases, the employee makes a contribution—if not the major share—toward the cost of coverage.

[14] Source: California Physicians' Service, Research Department.
[15] CMA Report, p. 37.

As to the relationship between plan and practitioner, CMA concluded:

> The estimated number of physicians who participate in providing service in these various plans is approximately 3,500 to 4,000 . . . Many of these physicians are primarily engaged in individual or partnership types of private practice and are usually remunerated on a fee-for-service basis. The most common remuneration for participating physicians in group practice is on a salary basis . . . Salaried physicians include those physicians who are members of medical groups. Generally, when a medical group participates in such a prepayment program, it is remunerated on the basis of capitation payment. This capitation payment may be based on (1) the number of persons enrolled in the plan, or (2) number of persons actually treated by the group. In some of these plans, provision is made to cover payment for services rendered by non-participating physicians. The payments may be based upon a schedule of indemnities, the physician's usual and customary fees, or on a predetermined fee-for-service basis.[16]

In closing this section it might be well to take note of certain conclusions reached by the American Medical Association's Commission on Medical Care Plans, as published in the AMA's Journal in January, 1959.

1. Closed panel, direct service, plans have not replaced other forms of medical care plans, but have stimulated some of the other plans to increase their coverage.

2. Lay administrators, solely, direct the activities of a small percentage of plans. *Administrators who do not realize the limitations of their medical knowledge may interfere with the proper performance of a plan and lower the quality and quantity of medical care rendered.*

3. It is increasingly evident that a trend is developing among some sponsors of plans and among some plans to require as a condition for enrollment that each member of a group be given a choice of more than one plan in the community.

III. Legal Status of Health Plans

From the standpoint of State regulation, health plans exist in a vacuum. It is true that all plans known to this committee are incorporated under the General Nonprofit Corporation Law [17] but its provisions for regulation and surveillance are more illusory than real, especially since the Supreme Court has held that the language of §9201—which is concerned specifically with health service organizations—"is permissive and not mandatory." [18]

A similarity between health plan coverage and disability insurance has been seen and this obviously accounts for this committee's interest in the matter. For years health plans have performed many of the services, and operated in much the same manner, as insurers, yet they have not been obliged to comply with the many provisions of the Insurance Code nor with the regulations and orders of the Insurance Commissioner.

In 1946 the issue came to a head when the Insurance Commissioner, Maynard Garrison, attempted to impose his authority on the largest health plan, CPS, and was, in turn, the object of a suit. In a legal milestone, Associate Justice Edmonds, in behalf of the California Supreme Court, observed that "it is a matter of common knowledge that there is great social need for adequate medical benefits at a cost which the average wage earner can afford to pay." [19] Then, turning to the point in dispute, the Court said:

[16] CMA Report, p. 38.
[17] Corporations Code §§9000-9802.
[18] *Complete Service Bureau* v. *San Diego County Medical Society*, 43 C.2d 201 (1954).
[19] *California Physicians' Service* v. *Garrison*, 28 C.2d 801.

> The business of [CPS] lacks one essential element necessary to bring it within the scope of the insurance laws, for clearly it assumes no risk. Under the provisions of the contracts or group agreements, it is a mere agent or distributor of funds. It does not promise the beneficiary members that it will provide medical care; on the contrary, "the services which are offered to . . . beneficiary members of CPS are offered personally to said members by the professional members of CPS . . ." *The professional member is compensated for his services solely from the fund created by the monthly dues of the beneficiary members* . . . Stated in terms of insurance, *all risk is assumed by the physicians, not by the corporation,* hence the only effect of requiring compliance with regulatory statutes would be to compel the acquisition of reserves contrary to the established method of operation.[20]

The court, then, has laid great stress on the question of whether the plan (or any such plan)—*as such*—assumes any hazard or risk. But the court found a "more compelling" reason for determining CPS not to be insurance.

> The question, more broadly, is whether, looking at the plan of operation as a whole, *"service" rather than "indemnity" is its principal object and purpose.* Certainly the objects and purposes of the corporation organized and maintained by the California physicians have a wide scope in the field of social service. Probably there is no more impelling need than that of adequate medical care on a voluntary, low-cost basis for persons of small income. The medical profession unitedly is endeavoring to meet that need. Unquestionably this is "service" of a high order and not "indemnity."[21]

Before passing on, an observation of Chief Justice Gibson who concurred in the opinion solely on the basis of legislative intent, should be noted.

> The true test is not the character of the consideration agreed to be furnished, but whether or not the contract is aleatory in nature. A contract still partakes of the nature of insurance, whether the consideration agreed to be furnished is money, property or services, if the agreement is aleatory and the duty to furnish such consideration is dependent upon chance or the happening of some fortuitous event. In the present case, the agreement is to make payments to member doctors for medical services to the beneficial members, and the duty to make such payments is obviously dependent upon chance or the happening of a fortuitous event, since the necessity for the services, and also for the agreed payment, is dependent upon the members' sickness or accidental injury.[22]

In its 1941 regular session the Legislature enacted §593a of the Civil Code which subsequently was transferred to the Corporations Code as §9201 *(supra)*. This eventually gave rise to a dispute for, as we have seen, §9201 is specifically addressed to nonprofit health plans. The San Diego Medical Society contended that the enactment of §9201 constituted legislative intent that *all* health plans be incorporated under the provisions of that section. Specifically, the society asserted that Complete Service Bureau [23] was engaging in the lay practice of medicine [because the physicians practiced medicine as a corporation as opposed to the method of operation utilized by CPS]; that CSB was engaging in fee-splitting [because a lay administrator directly and indirectly profited from the corporation's revenue]; that "commercialization" of medicine was part and parcel of CSB's plan of operation [because it solicited memberships from the general public]; and that CSB's advertising was misleading.

The issue eventually went before the Supreme Court and the conclusions reached by that body have been crucial to those health plans which deal with the public-at-large. On July 9, 1954 the court, in a 5-2 decision, sustained

[20] Ibid., p. 805. Emphasis added.
[21] Ibid., p. 809. Emphasis added.
[22] *Ibid.*, p. 811.
[23] Subsequently renamed San Diego Health Association.

the lower court's ruling in favor of CSB.[24] *First,* the contention that all health plans must incorporate under §9201 was rejected. *Second,* the court was satisfied that CSB's doctors were not interfered with in their practice by CSB's lay people. *Third,* the bureau's arrangement with its administrator to provide a percentage of each member's fee was upheld on the basis of allowable cost for operation and overhead. *Fourth,* the court ruled that CSB had not violated the hallowed ban of the medical profession against "cappers" or "steerers" (i.e., persons retained by doctors to refer patients to their offices) because its advertisements and solicitations promoted the organization and not its physicians. As to the charge of misleading advertising, the court reviewed each exhibit and found against San Diego Medical Society in each instance.

The general statements made relative advertising assurances of Complete Service Bureau seem somewhat tortured, yet it is impossible to comment on the points in controversy without having the particulars at hand. Let it suffice for the purpose of this report to note that the Complete Service Bureau case has constituted "the law" for health plans selling to the general public since 1954.

IV. The Committee's Investigation

To conduct the inquiry into health plans (as well as certain other related matters) Chairman Rees appointed a Subcommittee on Prepaid Medical Care with Asesmblyman Ronald Brooks Cameron as chairman and Asesmblymen John T. Knox, Robert T. Monagan, John A. O'Connell and Howard J. Thelin as members. The subcommittee conducted two public hearings.[25] With respect to health plans, the primary interest of the subcommittee has been in those plans who emphasize public solicitation but, as we shall see, there have been other matters (which would affect *all* health plans) of concern.

In the interest of brevity we shall cite several cases which have come to the committee's attention in the course of its investigation. In different ways these cases show in what respects the activities of health plans have aroused concern. The names of the complainants and of the plans are withheld lest the presumption arise that the plan is hereby indicated or condemned by the committee. **The committee's interest is primarily with the problems indicated below rather than with the merits or demerits of specific plans.** It should also be pointed out that the committee does not necessarily accept or agree with the viewpoint of the complainant; it *is* important to note what assurances, guarantees and illusions given or fostered by those soliciting memberships animate the consumer to choose a particular plan as well as the subsequent experiences which occasion disaffection.

A. One 55-year-old widow who is a diabetic committed herself to a membership agreement in one health plan on the salesman's verbal assurance that, among other things, she would be entitled to free medicine for her condition. (She subsequently discovered this was not so.) The conditional sale contract she signed categorically refers to the health plan as an "insurance company;" alludes to "insurance" thrice; and the line on which her signature appears is

[24] For citation see footnote #18.

[25] The hearings took place on January 29 (in the Los Angeles State Building), and November 30, 1962 (at the Student Union on the campus of the University of California at Los Angeles). Assemblymen Burton and Rees sat with the subcommittee in January and Assemblymen Levering and Mills—the latter at the special invitation of Mr. Rees—participated in the November hearing.

designated "insured." [26] Evidently more in ignorance than in guile, the salesman executed an agreement which called for the complainant to pay $940 in one cash installment for one year's coverage.

B. A lady was solicited for membership in one plan by a salesman who had general brochures on his person but did not "happen" to have a copy of the membership agreement. Although told that she would be entitled to 31 days' hospitalization at no charge, this lady declined to commit herself until she saw an agreement. When she did, she discovered that the standard provision on hospitalization was an allowance of $18 per day.

C. A man reports that, within a few months of purchasing one year's coverage in a plan, it went defunct. In the interval his wife had given birth to a baby and $156 of benefits to which they were entitled under their membership was not available. (The name of the principal in this plan, an osteopath, recurs in conjunction with two other plans known to the committee at this time.)

D. A 69-year-old retired woman who found her converted Blue Cross benefits inadequate to her needs made a sizable down payment on a year's coverage in one health plan on the strength of television advertisements and salesman's explanation of coverage. This party claims she was told that an X-ray of her gastrointestinal tract would cost "from $7 to $10." She called the office of the doctor assigned her and was advised the X-ray would cost $15. Following the X-ray she was asked to pay $25.00; in response to her query the receptionist explained that the fee was $35—"with $15 off."

E. An insurance agent who was excited about the sales possibilities of a new Los Angeles-domiciled plan, but worried about the absence of regulation, called this committee to learn something of the plan's reputation. Told that the name was unfamiliar, the agent volunteered to learn what he could of it and "report back." Two days later the agent related that he had attended an indoctrination session for prospective salesmen; that the sales people were told to assure customers they would be entitled to "full coverage" despite the fact that the plan provides only 20 percent of hospitalization costs and 50 percent of surgery expenses.

F. A 70-year-old gentleman paid $190 for one years' membership in a health plan. Thirteen months later he underwent surgery and hospitalization, in connection with a prostate gland difficulty, for which he was billed in excess of $900. Although he was not at that time eligible for the full surgical benefits offered by the plan (i.e., coverage for pre-existing conditions without qualification), he was supposedly entitled to "some" allowance on the cost of the surgery. Before the complainant could establish what this meant, the participating medical group which treated him withdrew from the health plan and he was transferred to another.[27] Efforts by the complainant to establish with the plan's "director" the discount to which he was entitled merely resulted in his being referred back to the disaffected medical group's administrator.

G. A lady who was subsisting on $69 monthly UCD benefits as a result of a nervous breakdown following the demise of her husband responded to

[26] The committee has discovered that, whatever mixed sentiments exist on the part of the public toward insurance companies, there is a confidence continually expressed in the *stability* and *ability to pay* of insurers.

[27] Although the logic to physicians is plain, it is baffling and exasperating to the complainant that he would have to undergo—and pay for in full—the same series of tests administered him by the original physician. Because his condition was now demonstrably "pre-existing" the complainant was entitled to no benefit from the health plan.

a newspaper ad offering to furnish descriptive literature on a health plan. While the lady was under the heavy influence of a sedative—and therefore scarcely cognizant of what she was doing—she was called upon by a salesman for the plan. She relates she heard his explanation of the plan while seated on her bed on which a sum of some hundred-odd dollars (her husband's life insurance) was lying. Following the salesman's departure she found a receipt for $92 cash indicating this to be the "cash sale price" of a year's membership. The complainant—who was in a near-hysterical condition when she complained to the committee—also found a conditional sale contract which showed she had paid $92 "down" on her "policy" and was obliged to make 10 installment payments of $8.10 each. The contract refers to the health plan as an "insurance company" and the lady in question as an "insured." [28]

One obvious characteristic of many of the foregoing cases is misrepresentation by ill-informed, disingenuous or over-eager sales personnel. Lest the conclusion be drawn, however, that this is the extent of the problem, it should be borne in mind that, under California law, an entrepreneur is substantially responsible for the acts of his salesmen. Moreover, it should be clear from several of the cases that management was fully as responsible for the illusions fostered by the salesman as the salesman himself.

At the January, 1962, hearing of the subcommittee some rather singular testimony was extracted from the manager of a young Los Angeles plan, variously known as Los Angeles Health Association and North American Health Association. Since the transcript of that hearing has been reproduced and its contents generally known, it would serve no great purpose to quote from it at length here. Suffice it to recall that LAHA's manager could not even describe to the committee in general terms the coverages available in his plan; could not recall what conditions would entitle LAHA to cancel memberships; could not remember whether certificates of membership provided members contained all conditions of entitlement; could not shed light on the demise of Los Angeles Beneficial Society [29] although he admitted to having obtained membership lists from its principal (Joel D. Neufield) whom he described as one of the "originators" of LAHA; could not recall the names of LAHA's board of directors—other than himself and two sons—nor could he recollect when the board last met.

Mr. Thomas D. Hodge of the Los Angeles Better Business Bureau pointed out at the same hearing that the BBB "has no legal powers or authority, so that if a complaint, even though it's meritorious, is disregarded, there's nothing we can say to the injured party except [to tell them] to resort to litigation. . . ." Mr. Hodge favored entrusting a government agency with authority to act against misleading advertising as well as consider and evaluate complaints claims service.

A similar point was made at the November hearing by Assistant Attorney General Harold B. Haas.[30] Commenting that a "gap in the law" had already been amply demonstrated in the course of the committee's investigation, Mr. Haas noted that health insurance policies are examined by the Department of Insurance and cannot be used prior to departmental approval. He also noted

[28] This is not the same plan as that alluded to under "A."

[29] Mr. Ted Ellsworth of the Institute of Industrial Relations, UCLA, testified at the January hearing that the Los Angeles Beneficial Society and the Union Labor Benefit League, although they advertised "non-cancellable" memberships, went defunct because their annual dues could not support the benefits guaranteed.

[30] Mr. Haas is the Justice Department's ranking authority on insurance law and served for nine years as Assistant Commissioner of Insurance.

that the department acts as "mediator" in disputes between insurers and insureds.

> . . . when I was in the Insurance Department hundreds of such claims were constantly in course of processing by what was then known as the Policy Claims Bureau . . . and thousands of dollars of . . . policyholders' recoveries occurred annually. It must be understood that there is no assertion here of intentional inequitable settlements by insurance companies. It is simply that with thousands of claims in process among hundreds of insurance companies, *human nature necessarily affects individual claims settlements and the commissioner's office affords the public an opportunity to obtain the analytical and expert advice relating to the interpretation of the policy;* to direct to the insurance companies' attention provisions, clauses and rules which can easily be overlooked by an adjuster passing on hundreds of such claims; and to give the insurance company an opportunity to reconsider the claim in view of new or different features called to its attention by the insurance experts in the department.[31]

Alluding to CPS v. *Garrison,* the witness informed the committee that after the Supreme Court rendered its decision former Attorney General Edmund G. Brown persuaded CPS to agree to let his office render the kind of service provided the public by the Department of Insurance.

> A similar arrangement was entered into with [Kaiser Foundation Health Plan] a few years ago, but this has been less satisfactory since the Kaiser contracts undertake reimbursement only in extraordinary circumstances specifically spelled out, and their undertaking is limited to affording medical service and hospital service at their facilities. Inasmuch as we were in no position to require them to afford more than granted by their contracts and had no control over their practices in connection with these contracts . . . we have taken up very few matters with the Kaiser organization *since our office is scarcely equipped either to determine adequacy of medical service or to issue requirements as to their contracts or sales practices.*[32]

Mr. Haas strongly emphasized that his comment in no way constituted an attack upon Kaiser Foundation Health Plan. But he noted, "it should be called to attention that **the total lack on the part of any State officer of the power to question any of these contracts or practices makes it impossible for me to make any statement either way. I just haven't the material."**

Mr. Haas went to the very heart of the matter when he observed that injury or illness itself is usually a financial strain, leaving little funds available with which to press a court action against a carrier. [Where there is a controversy over benefits for surgery and hospitalization in connection with, say, a duodenal ulcer, the insured or plan member not only has to find the money to pay his medical bills but runs the risk of developing still another ulcer from the tension and anxiety attendant upon such a dispute.] **Furthermore, Mr. Haas noted, "The people who have these claims appear quite often to be on an economic level which makes it impracticable for them to pursue any remedy of any kind to secure a reasonable and impartial review of the action by which they are deprived of benefits."**

The Kaiser Health Plan was represented at the November hearing by its chief counsel, Scott Fleming, who went on record as supporting legislation aimed at fraudulent advertising, high pressure and misleading sales techniques and deceptive contracts and cautioned that legislation should not go wide of the mark. He had an additional suggestion:

> Another area which very likely is appropriate for inclusion is some consideration of minimal standards for a direct service plan. This is a very difficult area because, if

[31] Emphasis added.
[32] Emphasis added.

> minimal standards are made too high, this can stifle constructive development. On the other hand, *there is evidence, I believe, to support the conclusion that a certain minimal level does need to be achieved before a program can fairly be offered to the public as constituting a direct service health care program.*[33]

Following, as it did, on the heels of a conference on regulation of health plans, the subcommittee's hearing at UCLA was enriched by the presence of doctors, health and welfare fund trustees, labor and management representatives, academicians, attorneys and, obviously, health plan officials. In summing up the "sense" of the conference, its chairman, Dr. John Beeston,[34] noted that the consensus of the participants was in favor of *some* form of regulation; that certain basic standards as to quality of service, facilities, personnel, etc., ought to be required; that some requirement as to minimum reserves ought to be established so as to eliminate "fly-by-night" operators; that full disclosure of plan benefits, restrictions, exclusions, etc., ought to be promoted.

Representatives of labor suggested that plans developed through collective bargaining, since they were the products of sophisticated and agile negotiators who knew how to protect their own interests, ought to be exempted from proposed regulation. Speaking for O. I. Clampitt of the Retail Clerks International Union, Local 1442, Ted Ellsworth argued that "Any organization that contracts for services for its own members should be allowed to do so." The right to arrive at contracts freely found no foes on the committee but Chairman Cameron was apprehensive that, if exemptions were not phrased quite meticulously, the intent of legislation might very well be negated. He alluded to the unruly and preposterous situation that developed in the field of "franchise life insurance" and provoked legislation in 1961.[35] Assemblyman Knox shared this concern.

Mr. Fleming, commenting that "there are some surrounding issues relating to conversion rights . . . to a forum for the consideration of grievances" suggested that:

> . . . it would be entirely feasible to develop a concept of administrative discretion to grant an exception in situations in which the public interest could be protected without the full regulatory mechanism being applicable.

The distinction between this position and that of Mr. Ellsworth lies in the outright exemption written into the law which the latter espoused in his apprehension that a regulatory body would be oppressive and meddling; Mr. Fleming would rely on the presumed good sense of the agency rather than tie its hands by statute.

As to the agency to be given responsibility, most discussion centered on the Department of Public Health. Anticipating that sentiment would favor this department, Chairman Cameron asked for the views of its director prior to the hearing. On November 26 Dr. Malcolm H. Merrill wrote Mr. Cameron as follows:

> We recognize the importance of the growth of direct service health plans to the protection and advancement of public health in California. Like others, we have wondered whether the time might be arriving for some type of regulation of these plans. In this connection we have considered our experience in the regulation of hospitals, nursing homes, laboratories and other direct health service activities. Also,

[33] Emphasis added.

[34] Dr. Beeston is an associate professor of preventive medicine and public health in the School of Medicine and an asosciate professor in the School of Public Health, UCLA.

[35] Cf. *Final Report of the Assembly Interim Committee on Finance and Insurance*, Vol. 15, No. 25 (1960), pp. 90-95. The report led to the enactment of Chapters 698 and 718, Statutes of 1961.

we have for some years certified hospitals for participation in the California Blue Cross Plans, using licensure of these hospitals as the standard.

If the Legislature should decide that some regulation of the direct service health plans is desirable, we believe that the State Department of Public Health is the appropriate agency to undertake the responsibility. You may be assured that we will try to carry out in the public interest and to the best of our ability any responsibility which the Legislature assigns to us in this matter.

The only formal expression contrary to this view has been that offered by A. B. Halvorsen, vice president of the Occidental Life Insurance Company of California who expressed his beliefs in written form on November 27. Prefacing his observations by asserting that his attitude was shared by the insurance industry generally, Mr. Halvorsen argued that regulation of health plans by the Insurance Commissioner "will assure the continued confidence of purchasers of health care coverages in the financial stability and integrity of voluntary health insurance."

V. Conclusions

The committee on Finance and Insurance finds that the time is overdue for closing the gap in the law on health plans. While the foregoing material shows that the overwhelming majority of Californians who are today members of health plans are not apt to be subject to the abuses which this report has focused upon, it is manifest that those members of the public who have been victimized and are about to be victimized are entitled to better protection than the law now provides them.

1. While prepaid health plans are in many ways similar to insurance and, as Chief Justice Gibson has pointed out, do in fact assume the responsibility to meet future contingencies, the direct service feature that is becoming an increasingly significant factor calls for special consideration. To assert that health plan contracts constitute insurance, pure and simple, because of indemnification features is analogous to insisting that porpoises are fish simply because they are found in the same environment.

2. This committee therefore recommends that the dual nature of health plans be statutorily recognized while perceiving their essence: their real (or professed, as the case may be) purpose in preserving good health and preventing ill health. There should be created a Bureau of Health Plans within the Division of Preventive Medicine in the Department of Public Health, which bureau should draw upon the procedures and expertise of the Department of Insurance insofar as action against fraudulent representations, provisions of contracts, licensing, inspection, standards of performance, and adjudication of disputes is concerned.

3. Since new ground is to be broken here and further, since the health plan field is a burgeoning one, the committee recommends the establishment of a Health Plan Advisory Board, to be composed of medical, public and health plan members, to advise the Director of Public Health.

4. Enabling legislation to accomplish these objectives should be carefully drawn so as to encompass all of the same species under the same regulatory "tent." The striking paucity of authoritative information on the extent and character of health plans is itself argument for establishing minimum reporting requirements. Beyond that, however, the Director of Public Health should

possess the discretionary authority to strengthen or slacken controls on health plans, according to his best judgment, acting in the public interest.

5. It is particularly crucial that a device be found whereby the public is given reasonable assurance that a plan which offers "coverage through age 99" today will not evaporate tomorrow, consonant with the objective of all reputable plans to pare costs and hold to the minimum expenses so as to provide health care at the lowest possible rate for subscribers. The committee does not at this time choose to specifically recommend the mechanism for achieving these two ends; *it is far better that the plans themselves find the way.* While care must be taken to always make it possible for new plans to enter the stage, for health is a commodity which has too few purveyors, there must be guarantees that the glowing promises made to the infirm and the aged will not, in time, turn out to be the cruelest deception.

Senator WILLIAMS. Thank you.

Mr. CAMERON. The first report, published in the spring of 1961, made a series of 16 recommendations to the California Legislature. Many of these recommendations are pertinent to the area of inquiry of your committee.

Foremost among these is the need to devise a method whereby the layman—aided by analyses in easy-to-understand language—can evaluate the relative benefits provided by various plans. Hundreds of times I have seen persons drop plans that provided far superior benefits to those being sold by a suede-shoe operator with a fancy pitch. They drop these plans because they mistakenly believe the salesman and they have no objective means to evaluate the relative benefits of the two programs.

Typically, persons will purchase a plan and pay more for it if it provides 90 days hospitalization, at $20 a day, and for a maximum total of $1,800, over a plan that provides 30 days hospitalization at $40 a day, for a maximum total of $1,200.

The second plan is far superior as to hospitalization if one considers that the average hospital stay varies from 5 to 7 days and costs per day vary from $30 to $65 depending upon the area of the country.

Also, the average individual tends to prefer indemnity-type benefits as opposed to service plan benefits, without realizing that in the typical cash indemnity program which we normally refer to as insurance, the company pays not more than 50 cents in benefits for each dollar collected in premiums; whereas, the typical service plan—such as Blue Cross—pays benefits well in excess of 90 cents of each dollar collected.

At present, I believe it takes too sophisticated a buyer of health benefits to overcome the purveyor's policy of caveat emptor.

I have long contended that the insurance and service plan trade associations in the health and accident field are destroying their industry by this policy of "let the buyer beware."

It is becoming patently obvious to the public that each year the cost of medical care as measured in the Consumer Price Index rises faster than any other item—and there is a direct correlation between this inflationary spiral and the funds that are bilked from a well-meaning and defenseless public in the name of health benefits.

I want to encourage you to be of stout heart as you pursue your inquiry, for you will surely suffer "the slings and arrows of outrageous fortune" from some of the greatest vested interests in this country. There is a great lobby composed of the insurance industry, the American Medical Association, the American Hospital Association, the direct plan writers, and the paramedical interests who will offer this committee lip service, but who have a vested interest in the status quo.

However, there is a greater lobby to whom we answer. There are 180 million persons in this country, most of whom at one time or another have had, or will have, a disservice done to them in the name of health benefits. This committee can help to protect the American people against such further disservice.

In closing I offer whatever service I may be able to give to this committee. There are many persons and organizations in California who are knowledgeable in this field, and I am sure they will be delighted to assist you in your study.

It is my pleasure to introduce such a person at this time. He is Mr. Charles James, who since 1961 has been California's assistant attorney general in charge of the consumer fraud section.

Mr. James.

STATEMENT OF CHARLES A. JAMES, ASSISTANT ATTORNEY GENERAL, SACRAMENTO, CALIF.

Mr. JAMES. Thank you, Congressman Cameron.

My name is Charles A. James, and I am the assistant attorney general in charge of the consumer fraud section of the California attorney general's office. I am appearing on behalf of Stanley Mosk, attorney general of the State of California.

We have been requested to appear before your committee today to discuss the problem of frauds and misrepresentations in hospital and medical health plans and the actions taken by our office to prevent misuse of such health plans.

Before talking about health plans, let me identify briefly the role of the California attorney general's consumer fraud section. We are a law enforcement section, concerned with the prevention of frauds on the consumer, whether in the health plan field, or in other fields such as deceptive containers, food freezers, water softeners, dance lessons, or health studios, just to name a few.

By statute as well as under his common law authority, the attorney general of California has a broad power to bring actions to enjoin violations of public policy statutes of our State. This is one of the basic tools of our section to prevent consumer frauds, and it was used to enjoin Western Medical & Hospital Plan, as I shall discuss later. I might point out that when we do bring a lawsuit we sue in the name of the people of the State of California.

I turn now to problems of frauds in medical and hospital health plans.

To put the problems in their historical context, I have first a few general remarks.

In a 1963 report, a California Assembly committee reviewed the history of health plans, extending back over the past century. In California, health plans have had an explosive growth over the past 30 years or so. However, the committee also pointed out:

> A fairly recent phenomenon (in the past 6 years or so) has been the emergence of health plans which have been primarily concerned with selling to the public at large through advertising in mass media and house-to-house canvassing which the older plans have not found necessary.

With respect to the legal status of health plans, the committee reported:

> From the standpoint of State regulation, health plans exist in a vacuum.

Unfortunately, this statement is true. In California, health plans may be operated as "service agreements" not constituting insurance and therefore not subject to regulation by our insurance commissioner.

Now let me turn from the general to the very specific. I would like to tell you about an appalling example of proven misrepresentations

in the matter of health plans. I refer to the matter of the now defunct Western Hospital & Medical Plan.

Western was incorporated in California in October 1961, and it appears that it ceased doing business completely a few months ago. So it was on the scene for about 2 years.

The Los Angeles office of our consumer fraud section has always had a comparative trickle of complaints about health plans that did not live up to their promises. But about a year ago, this trickle became a veritable flood, a major portion relating to Western Hospital & Medical Plan. Subscribers to the plan complained that they could not get medical services under the plan; that they were being dunned for payments even though no services were being provided or they had canceled their contracts; that they could not reach representatives of the plan; and that those who could reach the plan's employees were given no satisfaction. Eventually the complaints came down to the hard fact that Western was out of business.

I would like to review for you some of the false and misleading representations made by Western:

First. Western misrepresented itself as an "insurance" company. Western's conditional sales contract form referred to Western as the "insurance company," to the contract as an "insurance policy," to the subscriber as the "insured," and to the charges under the contract as the "premiums." People were thereby misled into believing that Western was an insurance company licensed and regulated by the California Insurance Commission. The proof of this deception is quite simple. A substantial number of the complaints received about Western were addressed to the insurance commissioner, who then transferred them to our office.

Similarly, another now defunct health plan advertised that its services were available to those who "have too little insurance—or none at all." Its form for requesting information provided boxes for the person making the inquiry to check whether he did or did not have "medical insurance now." From this, unsuspecting persons might unwisely infer that this health plan was an insurance company selling insurance, which it was not.

This approach—to make people believe that an organization is either approved, regulated, or supported by a known and respected type of institution—often governmental—is a common device to secure public confidence. Today, a health plan with the word "medicare" in its title advertises that it is "chartered by the secretary of state" without making clear that this is the California secretary of state, who has merely filed their articles of incorporation, an administrative function and not Mr. Rusk with some implied connection to the late President Kennedy's medical program.

Second. Western misrepresented that certain doctors and clinics would provide services under its policies. In August and September 1963, we contacted some 30 doctors, clinics, and hospitals that Western represented to the public were available for service under its plan. The response was frightening. Many doctors had terminated their association with the plan because of Western's failure to pay the capitation fee—this is the fee for each patient—as required under the agreement between Western and the doctors. Many were blunt in their comments: "Fraud type of procedure"; "this organization is a fraud"; "misinforms its clients as to what they are getting"; and

"salesman continuously misrepresented the services rendered and the relationship of the clinic to the plan."

Those were some of the quotes.

One hospital advised us that it had rescinded its agreement with Western in July 1963 for Western's failure to pay the previous few month's capitation fees, and advised Western that it would not provide hospitalization under the plan to Western's members. Nevertheless, Western for several months thereafter—even after receiving further notice from the hospital—continued to represent to prospective members that services could be obtained at the hospital under the plan.

Third: Western misrepresented that certain services could be obtained under the plan at specified savings, such as X-rays at the cost of $1. This was not so.

This house of cards collapsed in the following manner: Western failed to pay many of its doctors, who, in turn, canceled their agreements to provide medical or hospital services. Western went on representing that these services were available, however, in selling subscriptions in the plan to others. Unfortunately, many of these contracts were prepaid and many of the complainants did not realize the true facts until many months later when they first needed to see a doctor or go into a hospital.

In many cases, the complainant had signed a conditional sales contract to make monthly payments for the medical services. When it appeared that services were misrepresented or not forthcoming, the complainant would advise Western that it was canceling. Months later, the complainant would be dunned for collection of the balance of the contract by a finance company to which Western had sold the paper. Letters to Western were not answered. Calls to Western did not bring any satisfaction, and ultimately a call revealed only that the telephone had been disconnected.

On November 1, 1963, our office, in the name of the people of our State, sued Western and certain of its representatives to enjoin these false and misleading misrepresentations which also constituted unfair competition. On January 13, 1964, we had a final judgment by stipulation, and I would like to recite to you, if I may, three articles of the judgment which provides:

IV. Each of the defendants is hereby permanently enjoined and restrained from engaging in or performing, directly or indirectly, any and all of the following acts:

A. Making or disseminating, in any manner, false or misleading representations relating to the sale of health plans.

B. Making or disseminating orally, or by means of a printed advertisement, or in any manner, any statement or representations which could be construed to imply that—

(1) Western Hospital & Medical Plan, Inc., is a bona fide insurance company, licensed by the State of California and authorized under its laws to sell insurance policies in the State of California, unless such statement or representation is in fact true;

(2) Western Hospital & Medical Plan, Inc., will provide diagnosis, treatments, and X-rays at the cost of $1;

(3) Western Hospital & Medical Plan, Inc., will provide savings on eyeglasses, hearing aids, and dental care;

(4) Enrollment in any health plan offered by Western Hospital & Medical Plan, Inc., is a "limited enrollment";

(5) Western Hospital & Medical Plan, Inc. provides "worldwide emergency coverage," unless such statement or representation is in fact true—

I might comment on this worldwide emergency coverage.

It appeared that if, in fact, one should happen to be in Europe or some other place outside the continental limits of the United States and needed the services that were provided by Western Hospital & Medical Plan, he would first have to contact his doctor in the United States to get some approval before the plan would, in fact, become effective. This could hardly take the 24-hour type of coverage that was assured by Western Hospital & Medical Plan.

(6) Medical groups, including doctors and hospitals, will provide medical service to customers of Western Hospital & Medical Plan, Inc., when in fact these medical groups do not provide such services to customers of Western Hospital & Medical Plan, Inc.

C. Collecting, attempting to collect, or assigning for collection, any debt arising from a contract with a health plan member who was induced to enter into such contract by any of the representations included in paragraph III, B, 1–6 of this judgment; provided that this subparagraph shall not apply if:

(1) A health plan member has received services pursuant to said contract; and

(2) The contract did not contain the terms "insurance company," "policy" or "insurance copy" or any of these terms.

V. Defendant Western Hospital & Medical Plan, Inc. is enjoined and restrained from selling or offering to sell to residents of the State of California any type of health plan, unless such plan is approved by authorized representatives of the attorney general of California.

VI. For the purpose of securing compliance with this final judgment, duly authorized representatives of the attorney general of California shall, upon written request, and on reasonable notice, to any defendant, be permitted:

A. Access during the office hours of said defendant to all books, ledgers, accounts, correspondence, memorandums, and other records or documents in the possession or under the control of said defendant, which relate to any of the matters contained in this final judgment and which are located in the State of California; and

B. Subject to the reasonable convenience of such defendant, and without restraint or interference from such defendant, to interview officers or employees of such defendant, who are located within the State of California and who may have counsel present.

Upon written request from the attorney general or any of his duly authorized representatives, said defendant shall submit such reports in writing with respect to the matters contained in this final judgment as may from time to time be necessary for its enforcement.

Thus, Western is enjoined from misleading or defrauding the public. It is also out of business.

The foregoing discussion requires some evaluation in terms of the subject of interest to this committee; frauds on the elderly.

We know from the people we have talked to and the complaints we have been receiving that a large number of subscribers to Western were elderly persons. Health plan advertisements and flyers usually indicate that the plan is open to elderly persons. The common advertising phrase use is: "No age limit." Some specifically refer to "senior citizens." Western itself advertised that its plan was available "regardless of your age."

Elderly persons join health plans to protect themselves against the possibility of a large medical bill that might unduly strain their limited financial resources. They may prepay their yearly payment, or they may sign a contract to pay so much a month. It is no coincidence, we suspect, that the monthly payment under one of Western's plans was almost identical to the amount allocated for health insurance under our old-age assistance program. When the subscriber's need for medical services arises many months later, it is only then that

he learns of the plan's deficiencies. When the complaints come in, another period of time is required for our investigation and preparing legal documents. If there has been a substantial impact on the public, we bring suit to enjoin the method of operation.

Unfortunately, this procedure is not very helpful to the people who have paid for medical services they will never receive. Furthermore, our authority is limited now to prevent the scheme that can be proved fraudulent. Under existing laws, we cannot touch the borderline scheme, the grossly inefficient plan, the undercapitalized plan. However, whether failure of the health plan to perform what it promised is due to fraud or to gross mismanagement or to incompetence is of little concern to the people who have been victimized into making payments for medical protection they may need but will never get.

Here are some samples from our files that show the hardships on elderly complainants who have been unable to secure benefits they thought they were getting from the Western plan:

We are retired pensioners and cannot afford to take this loss ($76.56).

We are both drawing social security and do not have the money to pay the hospital, Dr. ———, or the associate, Dr. ———.

I hope you will be able to force Western Hospital to make some retibution [sic]. My mother and Mr. ——— are both over 65 and living on pension.

I am retired and I had taken out this policy with Western Medical & Hospital Plan in the hopes of having protection in my "retired days."

The complaints are still rolling in. Many people are still not aware that Western is out of business. One recent complainant signed with Western in August 1963. On February 17, 1964, he wrote to us:

Today (February 17, 1964) was the first time we had occasion to use the plan. We can go to any doctor but we don't like to be taken for $152 as I am retired under social security disability and we are dependent upon our social security payment * * *.

Some of the health plans in California present peculiar patterns of doing business. Some firms are formed, sell health plans, and then disappear. We have received complaints about health plans which have totally disappeared when we start looking into them, leaving only traces of their former existence. One of these firms paid its salesman 60 percent of the fee as a commission.

Another significant fact is the curious interrelationship between certain health plans. Our investigations show that a telephone bill for one defunct health plan was paid by an executive of another now defunct plan. In another case, the rental receipt for the offices of one plan was signed by a person connected with another plan.

We have also found that the health plans may be based upon an intricate business relationship so that the consumer cannot tell with whom he is dealing: For example, one firm will establish a health plan. It contracts with a second firm to run the health plan. This second firm will hire a third firm, with another name, to sell the health plan and will contract with a fourth firm to contract with doctors and provide the service sold to the members by the third firm.

From the foregoing, it is abundantly clear that enjoining misrepresentations by health plans is not a very satisfactory solution to the problems they create. That approach is too little and too late. It is too little because it can be directed only to provable fraud, to false and misleading misrepresentations; it cannot touch the more sophisticated and clever scheme or the mismanaged plan. It is too late be-

cause by the time that we can act to enjoin the misrepresentation, the consumers are already cheated, and perhaps the plan is defunct. Another plan can be easily formed by the promoters to continue in the same business. The plans, you see, are general nonprofit, the profits coming out in commissions and salaries.

From the foregoing facts, we also conclude that civil suits by the victims are also unsatisfactory to solve this problem. By the time the victim realizes that he should sue, the company may be insolvent and out of business. Furthermore, because of the peculiar pattern of business by health plans, which I have outlined earlier, it is difficult to know whom to sue or where to serve them.

The only solution is legislation providing for administrative regulation of health plans. Here again, a myriad of problems is presented. For example, how much regulation should be provided? What reserves should be required? What agency should provide that regulation?

The California Legislature has considered a number of bills to provide for closer control of health plans. None has passed as yet.

It is evident that legislation providing regulation of health plans by the States and by the Federal Government is a necessity. We are dealing with a creature that collects money from elderly people with limited incomes and resources upon its promise to provide medical services by others in the future. That creature, the health plan, is here in the present, when the money is to be collected. It too often disappears in the future, when the services are to be rendered. This is not to say that there are not reputable and well-managed health plans. There are some very old ones in California. But the opportunity posed to the promoter by the fly-by-night health plan scheme requires control.

However, let me make clear that I am not appearing as an expert to suggest what regulation should be enacted. I can only tell the committee that our present solution, the enjoining of misrepresentation by litigation, is inadequate.

Your committee is performing an important service in bringing out the facts about health plans. Investigation is the basic tool of the legislator as well as the litigator. In this area, we believe that your investigation will help point the way to effective control of health plans.

That concludes the formal presentation.

Senator WILLIAMS. Thank you very much.

Mr. Peacock.

STATEMENT OF ROBERT R. PEACOCK, SECRETARY-DIRECTOR, NEW JERSEY REAL ESTATE COMMISSION

Mr. PEACOCK. I am Robert Peacock, secretary-director of the New Jersey Real Estate Commission.

I want to thank you for giving me this opportunity to testify before your distinguished body, and particularly in connection with the important work we are doing involving the elderly in this country.

I want to concentrate today on the dealings which the New Jersey Real Estate Commission had and continues to have with Leisure Village, Inc., a condominium project presently under construction in Lakewood, N.J., for people 55 and older. I should hasten to point

out that I consider our affairs with this concern of particular interest because it indicates what could happen if there were no governmental agency or other central control organization to prevent certain types of exaggerated promotions.

Leisure Village is the first project of its kind in New Jersey and, New Jersey being relatively new to the whole concept of a condominium development, had to have suitable legislation passed in order for this type of development to come into existence. Governor Hughes just signed this legislation into law in January of this year.

The operation of Leisure Village was first brought to our attention in a referral from the department of banking and insurance, of which we are a division. This was in the form of a letter from Mrs. G. H. Eckerson, 92 Tappan Road, Harrington Park, N.J.

Mrs. Eckerson had written to officials of Lakewood Township to inquire about an article concerning Leisure Village which appeared in an advertising supplement in the Lakewood Daily Times on September 13, 1963.

Mrs. Eckerson said a great many claims had been made in the article "which seemed to offer tremendous advantages to a 'senior citizen.'" She wished to know "just what Lakewood as a town has contributed to make this possible."

She sent a copy of her letter to the Division of Hospital and Medical Facilities, Public Health Service, Washington. In this communication Mrs. Eckerson questioned a section of the article dealing with medical services.

She wondered about the accuracy of statements describing a medical care plan under which Leisure Village residents "will receive liberal out-of-hospital medical and doctor benefits," among other features.

The Bureau of Community Institutions of the U.S. Health Service sent a copy of Mrs. Eckerson's letter to the department of banking and insurance, which, in turn, notified the real estate commission of the matter. After a series of telephone calls and letters, Mr. Robert Schmertz, president of Leisure Village, Inc., and other officials of Leisure Village, were called to Newark to testify at a hearing conducted before me on November 21, 1963.

Also testifying at that time was Walter Young, an actuary of the department of banking and insurance, who appeared in the interests of Banking and Insurance Commissioner Charles R. Howell.

One of the issues developed during those proceedings was the question of the ethics employed by Leisure Village in its advertising up to that time. Of particular interest was a section of the ad in which prospective Leisure Village residents were told:

> To enjoy your fun to the utmost at Leisure Village, you should have frequent medical checkups for your continuing good health. And Leisure Village provides just that.
>
> Right on the grounds, there will be a complete medical building in which general practitioners and specialists will have their offices. You also get a group medical plan with comprehensive coverage including drugs and at-home visits by doctors.
>
> Big news: These services are all included in the easy monthly maintenance charge on the beautiful garden patio apartment you own.

This was part of several claims made by Leisure Village in a full-page advertisement which appeared in the New York Herald Tribune on September 20, 1963. In addition, brochures distributed by Leisure

Village at that time indicated that the development was offering phenomenal bargains on medical plan rates.

During the course of the hearing various officials of the real estate commission, as well as Waldo R. McNutt of the New Jersey Division on Aging, questioned the accuracy of medical service claims made by Leisure Village in its advertisements and brochures.

Participants in the hearing carefully reviewed the actual insurance plan which was being provided by the Continental Casualty Co. The question then arose as to whether or not the advertisement as set forth above had been referred to Continental Casualty Co. for its approval.

At the hearing it was admitted that this had not been done. Leisure Village officials claimed that the procedure pursued would consist of residents of Leisure Village calling upon their personal physicians for medical services and that Continental Casualty Co. would insure the payment for these charges.

Mr. Young said that in reality the policy in question "will insure the cost of medical services up to the doctor limits of the policy," and in "a great many instances" they will not cover the cost of services.

Mr. Young pointed out that this is an out-of-hospital policy which does not cover a bed patient. In other words, this policy has an aggregate limit of $5,000 for all calendar years.

For example, if a policyholder incurs medical expenses in the amount of $100, the first $50 is deducted, obviously leaving $50, of which the policy then covers 75 percent of that amount or $37.50.

At the time of this hearing the Continental Casualty policy in question had not yet been approved by the department of banking and insurance, even though many might have been led to believe otherwise by reading the Leisure Village ads and brochures.

After extended discussion, marked initially by the apparent reluctance of Mr. Schmertz and other Leisure Village officials to cooperate, it was ultimately agreed that the brochures would be changed as soon as practicable in order to clarify the real health benefits which were to be provided. As a result, the section of the brochures dealing with the so-called health protection plan contains this added note:

> The benefits of the medical plan described in this brochure are subject to limitations as to aggregate amount, a deductible amount, and a 25-percent coinsurance clause and other provisions set forth in the master group policy. A copy of the proposed group master policy written by Continental Casualty Co. and issued to Leisure Village Association may be examined by request at Leisure Village sales office.

While the end result of all the steps taken by the real estate commission in this matter would appear to be satisfactory, it cannot be overstressed that the commission never would have been called upon to exercise its jurisdiction were it not for the fact that the owner is also the holder of a real estate broker's license. If he was not one of our licensees we would have been powerless to act.

In summary, I would like to point out that I am here neither to approve nor disapprove Leisure Village. I have tried only to recite to you an incident which occurred in connection with a development being constructed for our elderly.

From our observation of the entire matter, this is not the most serious inadvertence—but neither is it to be taken lightly. The in-

accurate and misleading aspects place it within a somewhat indefinable gray area.

Thank you, Senator.

Senator WILLIAMS. Thank you, Mr. Peacock.

You have all given us a great deal to think about. We have more time to amplify more of the very helpful statements made by all three of you gentlemen.

One question directed right from the top of my head is whether Western, a California company, did any business outside the State of California, through mail orders or otherwise?

Mr. JAMES. I am not sure that they did business outside of the State of California. We do know that some of its business connections were outside of the State. We had evidence that some of the promoters or some of the people who were playing a very important part in the development of this scheme were located in a neighboring State, but we found this out only after rather extensive checking and investigation. To all apparent purposes the plan was operating solely in California, with all of its contacts in California, and this is the appearance they like to present.

Senator WILLIAMS. Western's operation, however, could be adapted to a mail-order business in other States; could it not?

Mr. JAMES. Very easily.

Senator WILLIAMS. Hypothetically, if Western did no business in California but was on file in the secretary of state's office and did exclusive business outside the State through mail order, would you have been able to reach them as you did?

Mr. JAMES. No; we would not have. Possibly with extensive cooperation from outside the State we might have been able to take some action to prevent the misleading schemes, but there has been a serious question of our jurisdiction in this matter.

Senator WILLIAMS. And it suggests that there are real gaps in statutory jurisdiction to come to early grips with these folks; is that right?

Mr. JAMES. As a matter of fact, Senator, I think the gaps are frightening in this area.

Senator WILLIAMS. Now, Mr. Henderson from the FTC indicated that companies that are doing business in other States and are not licensed in those States come under the jurisdiction of the FTC.

That is the one legislative authority, I would say, that partially fills the gap.

Mr. JAMES. I think the reference was made to insurance companies doing business in interstate commerce. You have to add those factors, too, in addition to the failure of the particular State to license or control the activity.

Senator WILLIAMS. Do you get any estimates of the total business of Western in terms of the total premiums they received?

Mr. JAMES. Our best estimate would be a very rough estimate, but we thought that it was approaching the millions, actually, in the short period of time that they have been operating.

Senator WILLIAMS. They operated for about 2 years?

Mr. JAMES. They operated about 2 years.

Senator WILLIAMS. Were most of the complaints you received complaints about the predatory practices of Western from elderly people?

Mr. JAMES. We think that most of them are. We have letters in the file that would give some clues as to the age of the people. They would refer to the fact that they were pensioners, they were retired, they had no independent source of income, and a majority of the complaints we received were from elderly persons, taking those clues into consideration.

Senator WILLIAMS. I have not read the Cameron report; it bears your name, does it not?

Mr. CAMERON. Yes, it does, Senator.

Senator WILLIAMS. But my most able assistant, Bill Oriol, here has, and tells me in his judgment it is excellent.

Does this deal with, after your findings, legislative suggestions?

Mr. CAMERON. Yes, there are a number of legislative suggestions, Mr. Chairman, which Mr. James hit upon. Unfortunately the California Legislature has not had the—you can supply the word—they have not enacted much of this. The pressures have been many and great from tremendous vested interests in this particular field.

I think that the import of your committee hearing, though, is something that we should all be very grateful for.

Mr. James referred to the fact that in Western's case a great many of the people appeared to be elderly, which they deducted from extraneous information. It was my findings over several years in California that the bulk of the employed people of the State of California—and I would assume this would apply throughout the Nation—are covered by some type of group plan through their employment; generally these tend to be extremely well regulated. There are obvious exceptions. Generally they tend to be very good.

What happens, though, a person terminates from employment, he is no longer involved in a group that can qualify for group benefits, he then becomes the prey of people such as Western, and I have seen this repeated time and time and time again, and, of course, I think that the import of what the FTC said this morning is very important; but, it limits itself, as I understand it, to insurance, and I think that you are going to see as your investigation develops that there is another area here which Mr. James was talking about, that of service plans, in which I carefully talked in terms of benefits rather than in terms of insurance, because these service plan groups are the ones that are easily formed, subject to very little regulation in any of the States, and are in a position to make a very attractive offering that is basically fraudulent in its inception.

Senator WILLIAMS. I wonder, Mr. Secretary Peacock, about Leisure Village and the medical services described as available within the village.

Has Leisure Village developed to the point where there are doctors in residence in the Leisure Village area?

Mr. PEACOCK. No; at the present time I believe there are 25 couples living in Leisure Village. I think they have a 100-unit condominium going up now, but the medical facilities such as the lab and so on that was mentioned in the brochure have not been constructed at the present time.

Now, they are planned; I should point that out.

I think this is one of the areas that at least New Jersey, I think, will have many more problems in in the future. I believe, at the present time, there are two developments, not condominium, though, just

straight old-age housing developments in New Jersey under construction or very close to under construction. One is for 2,000 units. The other is for 4,000 units. So you are talking about a good-sized development here in which I think the plans are to incorporate in this development almost a city itself with adequate medical facilities and doctors and so on and so forth.

I think the important thing to keep in mind is that the elderly of the Nation should have the opportunity of having this properly explained to them and exactly what they are getting for that particular premium they are paying or the overall rent or mortgage, whatever they are paying on their units. This is sort of a package deal. Sometimes they assume things that actually are not in existence, and, of course, one of the problems, at least it has been our experience, when the people do move, it is tough for them to move again once they pick up their stakes and go to another unit to live.

Senator WILLIAMS. Is this projected community you are describing a retirement community?

Mr. PEACOCK. Yes. I believe they are both being built, it might be with the assistance of FHA, with a couple of the larger insurance companies financing.

Senator WILLIAMS. The condominium concept was accepted nationally for FHA in 1961, and I gather it is springing up as the means of creating homes for elderly in many parts of the country.

Certainly one of the attractions of a retirement community for those who are promoting it is to provide within the area medical facilities. Therefore, I would think it is incumbent upon those of us in Government to not be the handmaiden, with our condominium concept in the housing bill, of misrepresentation and illusory promises.

Yes?

Mr. CAMERON. Mr. Chairman, on that very point, we in California have many condominium projects that are financed under FHA—I can think of several that presently have occupancy in excess of 10,000; and many more that are under construction. And it occurred to me that possibly this is an area that through the FHA, the Federal Home and Housing Agency, they should be taking a very serious look at. In one particular unit that I am familiar with, the plan with regard to medical benefits was sold not dissimilar to that that Mr. Peacock described. Subsequently, it was found it was not an insured group at all, but rather it was a closed panel medical group that was being set up within the condominium project and there were no hospital benefits available under the program.

Senator WILLIAMS. Well, I would think that where the development has FHA guarantees, there ought to be, even presently existing authority for FHA, to evaluate it——

Mr. CAMERON. Apparently it is my understanding, sir, that this has been outside the purview of the FHA to date with respect to the medical benefits sold. They are concerned in financing and providing the other facilities, but the medical group facility is built by private funds, not financed, that is the clinic facilities built by private funds, by private finances, and is an ancillary benefit to the project, though this tends to be the one that is promoted and is foremost in the minds of the purchasers of the property.

Senator WILLIAMS. I smell a little amendment coming on here when the housing bill comes up.

Mr. CAMERON. I think it certainly should be considered.

Senator WILLIAMS. I think you have opened the door on an absolutely essential query as far as I am concerned.

I do not want to monopolize things here, but to get some appreciation of these retirement communities, particularly under condominium—the contract is a purchase in fee of your apartment; that is what it amounts to?

Mr. PEACOCK. Yes, sir.

Senator WILLIAMS. The payment comes monthly probably like rent, but it is not rent——

Mr. PEACOCK. It is paying a mortgage, Senator.

Senator WILLIAMS. For the average-sized apartment, say a two-bedroom apartment, what are the monthly mortgage payments?

Mr. PEACOCK. I cannot give you the exact monthly mortgage payments because it is a matter of down payment, but speaking with respect to Leisure Village, I am not so sure it would be a good example for the simple reason I think it is rather an expensive condominium for people to move into. I believe it starts somewhere in the area of $14,000 or $13,000, or in that area, but from what we understand, most of the elderly going in there are either buying their unit outright and very few of them are holding mortgages on it. So, it would indicate that the income of these people when they are retired is probably above that of the average. I would think so.

Senator WILLIAMS. But, whether it is purchased outright or whether on a time basis with monthly payments, the payment includes the medical area benefits, like the Thomas Medical and Health Services?

Mr. CAMERON. Most of the ones I am familiar with in California, sir, are set up so that you have two monthly payments, one going to the organizational structure that has the commitment from FHA and another one going to the association of members which provides for clubhouse benefits, the putting green, the medical benefits, et cetera, et cetera, et cetera. So that there is a separation in legal entities between that that operates the property and that that operates the ancilliary benefits.

Senator WILLIAMS. Senator Fong?

Senator FONG. I think with the FHA benefits for the condominium buildings, you are going to run far afield, because as far as I know, the condominium idea is purchasing a lot in space, and the FHA comes in only to take care of the mortgage to insure that the man who buys it is able to pay; if he is not able to pay, then the man who lends the money will be paid. Then the agreement made with the individual is that he pays for that unit that he purchases.

Senator WILLIAMS. But the whole deal lacks integrity if something is costing a lot of money and the services are not being provided. This puts a taint on FHA, I would think, if they are, through their guarantee, making it possible for the promoters to do something wrong.

Senator FONG. The promoters could enter into any kind of agreement with the people who are selling services in town, like the dentist or the garage man, the repairman; and if the condominium purchaser wants to enter into an agreement like that, he could enter it. That is why I feel it is going to be very difficult for the FHA to really enter into this phase of the frauds on the elderly which we are now considering.

Do you have regulations in the State of New Jersey regulating what you can do in a condominium and what you cannot do as to the purchase of a condominium? How much must be done in the effectuating of the plan so that it will be not a fraud on the person who buys the condominium?

Mr. PEACOCK. There are no regulations at the present time, Senator. As I tried to point out, this is a completely new concept, really, to New Jersey. Governor Hughes signed the condominium bill which was not in existence before in New Jersey, only in January. In fact, this held up the tax structure on Leisure Village before they could actually figure out the taxes. They had to wait for Governor Huges to sign the bill. It is completely new to us and we are getting into this area and I think it would be safe for me to say in the very near future there will be rules and regulations adopted that will cover this area. We are rather new in this. I believe California, Florida, some of the other States, perhaps Hawaii even, have known this concept before.

Senator FONG. I think we were the first State to pass the condominium bill.

Mr. PEACOCK. Yes, sir. In fact, I know we have written to the head of your real estate commission in Hawaii for a complete list of rules and regulations that are in existence in Hawaii. And California and Florida, the States we know have had experience in this area.

Senator WILLIAMS. Puerto Rico has experience.

Senator FONG. This is a Latin American concept and it has been incorporated into the American way very, very recently, so we are going to find we have a lot of areas to explore, and we are going to find there are going to be a lot of headaches because there will be many unscrupulous people who will be back of condominiums and they will not provide the things they say they will provide. And I think your New Jersey Commission should really look into that, because if you do not provide for them, you are going to have a lot of trouble.

Mr. PEACOCK. Thank you for the advice. I will follow that through.

I do believe we are going to run into many problems. I think in this type of building it is almost built in there, especially with recreational facilities, roads, medical services, and so on; you will run into some real problems.

Senator FONG. Mr. James, do the laws of California give you the power to punish the officials of Western for their pattern of deceit?

Mr. JAMES. We would have to rely on our general penalty laws related to——

Senator FONG. Deceit and fraud.

Mr. JAMES. Deceit and fraud, obtaining money under false pretenses, providing we could prove this, and this would not be an authority that our office would exercise, but it would be an authority that would be exercised by the district attorneys of the 58 counties.

Senator FONG. Would you say with all the recitations you have given us of the various deceits and frauds which were carried out by Western that you have ample ground for criminal statute in the offices?

Mr. JAMES. Criminal activity in that particular case?

I think there is sufficient ground to perhaps prosecute provided you could find the responsible individual in that particular situation and provided, too, that we could have produced enough evidence with the results we have. Now, there is a several-stage process in getting to

the point of prosecution. Our action was civil in nature and it did not require the amount of proof that would be required in a criminal prosecution. The criminal prosecution would be related to individuals, not to the corporations as a whole. We think the prime individual in this case was one that was beyond our jurisdiction.

Then, too, one other difficulty is that we would have to relate this to the particular county and start the action there.

The district attorney of Los Angeles County did investigate this and after our action was initiated concluded this would suffice for the purposes of stopping the activity, that the company had gone out of business.

Senator FONG. If they had a domicile in another county you could have gotten the State attorney general's office to go after them?

Mr. JAMES. No; still the other county would be involved.

We attack the problems that are—that flow across county lines because it is extremely difficult for the district attorney of a particular county to gather enough evidence of activity within his county to prosecute. This is true not only of this type of operation but also of many other consumer frauds.

Senator FONG. When you found a man was paying rent for some of the services of one company for another company, you actually followed that pattern of deceit?

Mr. JAMES. Of course, we had to find here was the very nexus of the wrong being committed. This is a suspicious circumstance, but we cannot take action based on suspicion alone.

Senator FONG. Do you think there should be an insurance commissioner of the State to take care of matters like this?

Mr. JAMES. Our State has an insurance commissioner, but these health plans, these service plans are outside the scope, they are outside the jurisdiction of the insurance commissioner because they are not insurance—legally they are not insurance.

Senator FONG. If these were insurance policies, your State commissioner could have done something about it?

Mr. JAMES. That is correct, he would have had jurisdiction then.

Senator FONG. He would have had ample power against the insurance companies?

Mr. JAMES. If they were insurance companies, he would have had power to take action after these offenses had been committed.

However, the one problem here, Senator, is that this particular service plan was representing itself as an insurance company.

Senator FONG. Yes.

Mr. JAMES. When, in fact, it was not.

Senator FONG. You could have gotten somebody to enjoin them from using the word "insurance."

Mr. JAMES. That is what we did.

Senator FONG. But it took you a long time.

Mr. JAMES. That is the problem we are trying to point out; it takes a long time.

Senator FONG. If the regulatory body having the power of handling situations like this, where it is not an insurance policy but a health plan which you have recited, do you think you can get faster results?

Mr. JAMES. Well, we think we would have preventive enforcement rather than enforcement after the fact. We think this is the important crux of this. If there is a plan for registration of the companies

in order for them to qualify to do business in the State, then first of all, we know where they are located. Secondly——

Senator FONG. In other words, you are proposing that before they can do business, after a licensing can issue to them, that they have to meet certain requirements, like having so much capital?

Mr. JAMES. Exactly.

Senator FONG. Is what you are looking for a contract which would stand up with the doctors, like a plan which the commissioner would be satisfied will be workable?

Mr. JAMES. Yes.

Senator FONG. Congressman, I was quite interested in the statement you made here. Your testimony states that it is before the subcommittee on frauds and misrepresentations affecting the elderly, and you had a paragraph here in which you said:

> There is a great lobby composed of the insurance industry, the American Medical Association, the American Hospital Association, the direct plan writers, and the paramedical interests who will offer this committee lipservice, but who have a vested interest in the status quo.

Now, taking into consideration we are now talking about frauds and misrepresentations affecting the elderly, I do not think you mean that the insurance industry is against cracking down on the medical frauds?

Mr. CAMERON. Oh, but I do, sir.

Senator FONG. You do infer here——

Mr. CAMERON. Let me say, Senator, as an example. Mr. James just pointed out to you that the insurance commissioner in the State of California does not have jurisdiction over the service plan groups. I think he should have. I tried to get that legislation through for years. I was not successful. The reason I was not successful is because of a group, which is a nationwide group, the Blue Shield, which is the physicians group that has their own medical policies they sell in competition to the Blue Cross group. You have two competing organizations—Blue Cross controlled by hospitals, Blue Shield controlled by physicians.

Now, the reason you cannot get an insurance commissioner control over the service plans is because Blue Shield is a service plan run by the physicians of the State of California. They do not want regulation by the insurance commissioner. Therefore, they have been able to keep legislation from going through that will do such things as we need to do with organizations such as Western.

Now, this is not an indictment of Blue Shield, this is not an indictment of the quality of service performed, of the ethics of the organization. It is an indictment of them, though, in the sense that they are denying proper regulatory authority through their lobby to keep fraudulent people from using the same little quirk in the law that they happen to be taking advantage of.

Senator FONG. Let me correct that; Blue Shield is not an insurance policy?

Mr. CAMERON. No; it is a group service plan.

Senator FONG. What you mean here is they do not want to be brought under the regulatory powers of the insurance commission?

Mr. CAMERON. That is right.

Senator FONG. That they are preventing the insurance commissioner from having the jurisdiction over group plans like Western?

Mr. CAMERON. That is right; and Blue Shield is doing a fine job; this is no indictment of them. It is an indictment, though, of their policy of exempting themselves out under law and allowing all of the questionable organizations to use this same particular quirk in the law to their benefit.

Senator FONG. I asked you this question to clarify.

Mr. CAMERON. This is what I am meaning, sir, when I say these organizations have a vested interest in the status quo. They are not desirous of additional regulation that might in some way regulate them.

This is not intended as an indictment of many, many, well-meaning people that fall within all of these categories. But I think it is a very shortsighted view on their part. And as I said, also, in my statement, I think they are in the process of destroying their own industry.

I personally am opposed to a socialized medicine plan for the United States of America. I think these people are bringing it upon us.

Senator FONG. I asked you this question to clarify your thinking on it because from reading this I get the impression that you are saying that they are against trying to crack down on these practices.

Mr. CAMERON. Thank you for helping me clarify it, sir.

Senator FONG. You do not mean that?

Mr. CAMERON. We are in an area of semantics. I think that they are opposed to the extent that they would be subjected to additional regulation. They feel that the persons who are now defrauded are so miniscule in their eyes in relation to the total picture that it does not warrant additional regulations. I do not feel this way at all. I am concerned about these people who were with Western.

You asked the attorney general here what could happen, how could we prosecute them? As a practical matter, there is no way of prosecuting. The people defrauded were defrauded of $50, $75, $100, $150, small amounts, all over town. It is difficult to build up one surge of support for one man defrauded and you cannot get them all together. You get a Billie Sol Estes type of headline and we can get regulation. But when it is all these innocent people, one here, one there, in each block, who have no way of becoming cohesive, they have no way of fighting vested interests other than through us.

Senator FONG. You do not mean they condone these fraudulent practices?

Mr. CAMERON. Yes; condone by not putting forth leadership—they in my judgment should be giving the leadership. The chairman, when he started off, said that the health plan industry had been invited to testify; they have not come to testify. The transcript is being left open for them. This is what I am talking about in terms of lipservice. I have had this for 4 years in California. They would come around and say, "We are with you all the way," pat you on the back, encourage you like mad. When it gets down to the gut fighting they are out there lobbying against your bills.

Senator FONG. What I am trying to do is get the record straight, whether you are stating here that the doctors are condoning the fraudulent practices that are going on? I do not think you mean that. What you mean is that by not giving help, by not committing themselves to the regulatory powers of the insurance commissioner, they are in a way allowing these other fraudulent practices to go on. I think that is what you mean.

Mr. CAMERON. I will accept that, sir.

Senator WILLIAMS. Do we not have some analogies to errors of omission and not commission here?

Mr. CAMERON. That is it, sir. But in this particular instance, in my mind, I think they are almost errors of commission, because I think that the responsibility of the hospital industry and the medical professions is such that they should be providing the leadership in this area and not dragging their feet, and I think by omission they are almost guilty of commission.

Senator FONG. Is Blue Cross an insurance policy?

Mr. CAMERON. It depends upon the State. There are, as I remember, about 90 Blue Cross plans across the United States. They operate in different ways in each of the several States.

In California, it does fall under the jurisdiction of the insurance commissioner. I cannot tell you with regard to the other States.

Senator FONG. And the majority of health policies are written by Blue Cross?

Mr. CAMERON. No; I do not believe that to be true, sir.

Senator FONG. That has been the testimony before us.

Mr. CAMERON. This may be on a national basis. I know in California this is not the case. Blue Cross is writing approximately 30 percent of the coverage in California. We have two Blue Crosses, one of the north and one of the south. We have some very large, very good direct service plans such as Blue Shield, Kaiser, Permanente Foundation, Ross-Loos Foundation, who are direct service writers.

The indemnity-type insurance industry in California provides the majority of the benefits.

Senator FONG. And Blue Shield is not an insurance policy in California, but Blue Cross is?

Mr. CAMERON. That is correct, sir.

Senator FONG. The medical part is not but the hospitalization is?

Mr. CAMERON. Well, they have bastardized this thing over a period of years, sir. Originally Blue Cross started out for the purposes of providing methods of paying hospital benefits. It was controlled by the American Hospital Association and its affiliated groups. Their witnesses are here. I am sure you can talk to them about this.

What happened, they only paid hospital benefits; they paid no doctor benefits. Then Blue Shield came along. Blue Shield paid only doctors, no hospitals. Then, during the 1940's when we had the freeze on salaries and you could not raise anybody's salary, this is when we got the great impetus to health plans, this is how they provided additional compensation to all these people covered by wage stabilization. At that point there became great competition in the health plan industry. I used the word "bastardizing," they started writing an insurance policy in conjunction with it to provide doctor's benefits. When this happened Blue Shield worked the other way around, they then went out and bought a commercial insurance policy to put together with their policy.

Blue Cross pays less for hospitalization in any hospital than an insurance company pays for the hospitalization, because under your Blue Cross contract, the hospital is limited to a 6-percent return. Plus, if Blue Cross does not show a profit, the hospital agrees to take a reduced benefit. If we lose 3 percent this year, instead of making a

6-percent profit, all of the member organizations only get 97 percent of the bill paid. Blue Cross works as a co-op.

Blue Shield in California went bankrupt back in 1937 or 1938, something like that, and they were only able to pay the physicians 40 cents on the dollar, and for 3 years they were not able to pay the full benefit that was due. The person received the service but the physician who performed the service received a lesser amount, because he belonged to this co-op.

The physician's Blue Shield program with regard to hospitalization, though, is a straight insurance contract; and conversely Blue Cross is an insurance contract with respect to medical services. It is not a co-op there.

Senator FONG. Thank you.

Senator WILLIAMS. Senator Keating?

Senator KEATING. I am sorry I was not able to hear all of your testimony and therefore my question may have been covered already in your testimony.

Blue Cross is regulated by the laws of California now but Blue Shield is not?

Mr. CAMERON. That is correct, Senator Keating.

Senator KEATING. Is not Blue Shield regulated by the laws of some of the States?

Mr. CAMERON. I cannot speak for all of the States. I would assume that it is, sir, but I am not that familiar with the organizational structure.

Senator KEATING. Are you suggesting that Blue Shield should be federally controlled in some way?

Mr. CAMERON. No; I am kind of in the position that Mr. James is here in, Senator. I am not advocating specific regulation. I think that one of the functions that your committee can serve is to bring national recognition to the problems of fraud and misrepresentation, as applied not certainly to Blue Shield; as applied to these fly-by-night service plan operators and some extremely marginal insurance companies who have acquisition costs totally disproportionate to their benefits.

There is an annual reporting put out by—I cannot think of the name right now—anyhow, it is within the insurance trade, the Library of Congress has it, and you can go right down the line, looking at the premium charge in the health and accident field, then you can look at the percentage of the premium paid out in benefits and the percentage of the premium paid out in commissions and you single out those companies that pay out percentages of benefits less than 25 percent of the total dollars collected, and without exception I can find you letters in my files showing direct fraud in these companies.

Now, this is the area that it seems to me you can do something about, the condominium thing we can do something about, and possibly there is an area of regulation with respect to bringing all purveyors of health plans under FTC-type of purview with regard to fraud. I think this would be a helpful thing. I am not suggesting that the Federal Government should inject itself into insurance company or service plan regulation from an economic standpoint.

Senator KEATING. That is what I wanted to clarify. There is the school of thought along that line.

Mr. CAMERON. I do not happen to subscribe to that, sir.

Senator KEATING. You then apparently are in no disagreement with my views; namely, that the regulation of insurance should be handled by the States and not by the Federal Government?

Mr. CAMERON. Absolutely, Senator.

Senator KEATING. What are direct plan writers?

Mr. CAMERON. Persons, closed panel groups essentially is what I am trying to describe here, sir, where you enter into an agreement with an organization that agrees to provide you with medical services and hospital benefits by predetermined physicians and at predetermined locations. Some of these are excellent, some of them are terrible. Western, which Mr. James described, was one of the terrible ones.

Senator KEATING. Why is it not called an insurance company?

Mr. CAMERON. Because it is not insurance in the sense that they do not agree to indemnify you for your loss. This is the basic concept of insurance; you incur a loss, the insurance policy indemnifies you for a loss. This is not what is involved in these groups. These groups agree to provide you with a service.

Senator KEATING. That is what Blue Cross does.

Mr. CAMERON. Well, this is true. Blue Cross provides you with a service as to hospitalization. It does not provide you with a service as to doctors. It provides you with indemnity, indemnification here.

Senator KEATING. Blue Cross is very generally regulated by State insurance departments, is it not?

Mr. CAMERON. Yes, it is, but the reason is that they are providing—of course, Blue Cross provides all sorts of things; it used to be 100 percent coverage, now they have limitations of all sorts, there is no community rating approach, it is strictly an experienced rated program. What's the chances of Senator Keating having some type of hospital disability this year, and they look it up to the scale and that is the premium they charge you instead of the community rating they originally started out with. But they do provide you with indemnification, out-of-pocket expenses with respect to your doctor's bill. The doctor may charge you $1,000 for an operation, the limitation in their schedule may be $300, but they will reimburse you on that basis, so this puts them in the insurance business.

These other groups provide none of this. They will not pay you for physician's services. They will not pay for hospital services. They will only provide the doctor and provide the hospital.

Senator KEATING. In your statement you refer to the paramedical interests. What did you mean by that?

Mr. CAMERON. Oh, all sorts of people who are involved in this: the pharmaceutical industry, the nursing associations, the dental associations, and all of the groups that are not either hospitals or physicians.

Senator KEATING. I think probably Senator Fong cleared up the implications that might arise from your statement about what most of us consider is a very reputable organization and certainly I have not seen any evidence of improper pressures being brought to bear by any of these groups. I know a great many of the leading physicians in those organizations and while I have had some difficulties with them from time to time, I would say that they are all as anxious to get rid of the quacks and improper operators as any of us would be. Thank you very much.

One of the witnesses has to testify before 1 p.m. Senator Williams had to leave temporarily. I think he said it was Mr. Colburn of Detroit.

Is Mr. Colburn in the room?

Am I correct, Mr. Colburn? Am I correct that you must catch a plane and that you asked to be called out of order?

Mr. COLBURN. I had discussed it with the staff man that we would be able to start before that time and finish up after the break.

Senator KEATING (presiding). You wanted to complete your testimony by 1; is that right?

Mr. COLBURN. I don't think we can, but we can get a good deal of it out of the way, sir.

Senator KEATING. You are not the next witness. I just want to know whether Mr. Colburn is to be called out of order. Apparently he is not the witness to whom the chairman referred.

The next witness is Mr. T. Nelson Parker, insurance commissioner of Virginia.

Mr. PARKER. What I have been asked to do, Senator Keating, is to read a statement of Mr. William R. Morris, superintendent of insurance of Ohio.

Mr. Morris was unable to be here——

Senator KEATING. From Ohio?

Mr. PARKER. Yes, sir.

Senator KEATING. How is Virginia connected up with Ohio?

Mr. PARKER. We happen to be closer to Washington than any other State, with the possible exception of Maryland, and, of course, the District of Columbia, and those two gentlemen could not come here so they asked me to come and read this statement.

Senator KEATING. You occupy in Virginia the same position which Mr. Morris does in Ohio?

Mr. PARKER. That is right, sir.

He expresses his regrets for not being here and gives his reason. I will not read that to save time.

STATEMENT OF WILLIAM R. MORRIS, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, PRESENTED BY T. NELSON PARKER

Mr. PARKER (reading): My name is William R. Morris and I am director of insurance for the State of Ohio. I am speaking for the National Association of Insurance Commissioners as a member of its executive committee.

We of the NAIC appreciate this opportunity to add the voice of our association to the warnings sounded by this committee concerning various schemes preying upon the older citizens of this country.

There is one aspect of the insurance business which in our opinion deserves comment during this series of hearings. This concerns solicitation of insurance through the mail by unlicensed companies.

With a rather short notice for this appearance, it has been impossible for me to poll our entire membership as to the extent of the mail order activity in each individual State.

However, I can present the position of the association and outline much of the activity which has taken place in NAIC and in the individual States in order to meet this problem.

As you know, the National Association of Insurance Commissioners is a voluntary association of the heads of the insurance departments in the several States. Membership includes the commissioners of all of the 50 States, plus the District of Columbia.

The association furnishes consistency and continuity to the regulation of insurance in this country while, at the same time, enabling the individual State departments to be responsive to the special or unusual situations which may pertain in their individual States.

One of the primary duties of a State insurance commissioner is to issue licenses to companies domiciled in other States and which meet certain strict entrance qualifications. The license, in turn, gives the insurance department control over the companies, enabling it to disapprove of any illegal practices with regard to the form of the insurance contracts and the rates charged, as well as to investigate complaints concerning handling of claims involving citizens of the State.

The comments we make today and the problem we would bring to the attention of our citizens concerns insurance sold by mail, and the advertising of these contracts in certain interstate publications by companies not licensed in the States to which they direct their sales efforts.

By way of placing the subject of your hearing in perspective, it has been estimated that the amount of direct mail health insurance is probably less than 1 percent of the total health insurance market in the United States, and only a small portion of that 1 percent is issued to persons age 65 and over.

At this time, I should interject to point out that our criticisms of these few unorthodox mail order companies should not create confusion as to all insurance plans which are being sold to older people.

There are a number of private companies which have special plans for senior citizens and which are sold only in States where these companies are licensed.

In addition, there are a number of State-65 plans whereby a number of licensed companies pool their resources in order to furnish a market designed to meet the needs of older people.

Already the State-65 plans are operating in Massachusetts, Connecticut, New York, California, Ohio, Virginia, and North Carolina, with a number of other States to follow.

Finally, the various service plans, commonly known as Blue Cross, are being actively sold to senior citizens. All of these companies and plans are meeting a need effectively under the supervision of State insurance departments.

Inasmuch as these so-called mail-order insurance companies do not become licensed in many of the States to which they send their solicitation, the purchasers of their policies do not have the full benefit of the facilities of their respective insurance departments.

Policy forms are not presented to the insurance department for review and approval and the department is thus unable to reject those forms which might be unfair or illegal. Also, complaints from policyholders who believe that they have not received fair treatment in the settlement of claims are somewhat more cumbersome to handle by reason of the unlicensed character of the activity.

Thus, although a problem definitely exists, we do not wish to leave this committee with the impression that the State regulatory officials

are doing nothing to protect their older citizens. If I may, I would like to spend a few minutes demonstrating that the States are far from helpless.

An examination of the statutes of the various States reveals a comprehensive system of legislation designed to regulate the business of insurance in virtually all of its aspects, including advertising, and invoking a broad pattern of judicial and administrative remedies in support of such regulation.

The details of this scheme of regulation are not, of course, uniform throughout the States. The National Association of Insurance Commissioners affords an influential and useful nationwide means for the collection and exchange of information on problems created by such regulation and suggestions for its improvement, and by its model acts, it has encouraged a certain uniformity of legislation.

The principal regulatory authority of State insurance commissions to control advertising is contained in the State Fair Trade Practice Act, some variant of which is now in force in every State.

This act was drafted by the National Association of Insurance Commissioners. Citations to this model act as adopted in each State are set forth in appendix A. The language of the model act itself is found in "Proceedings of the National Association of Insurance Commissioners, 1947," pages 392–400.

Neither Oregon nor the District of Columbia employs the specific language or organization of the model act, but each jurisdiction has enacted statutes which comprehensively regulate advertising (see District of Columbia Code sec. 35–409, 410; Oregon Rev. Stats. sec. 736.608).

In addition, the NAIC has also developed a comprehensive advertising code and has coordinated the contents of such code with the avertising standards of the Federal Trade Commission.

As noted, the National Association of Insurance Commissioners as a body has been dealing with this and related problems since as early as 1947. These matters have been considered often and at length. For example, at the last meeting of the association, in Phoenix last December, a prominent item on the agenda was a report of the advertising in insurance committee, dealing principally with advertising and other activities of these unlicensed mail-order companies.

A further report of this committee will be presented in Minneapolis in June, including a draft of a model advertising bill for the States to use in controlling advertising practices in this field. In addition, other aspects of the problem concerning the enforcement of the laws of the individual States, which I am about to consider, will be discussed.

In March, zone II of the association, consisting of nine States of this part of the country, plus the District of Columbia, met in Columbus, Ohio. An excellent session was devoted to unlicensed mail-order insurance companies, concentrating on the legal weapons and areas of mutual cooperation available to the individual States in controlling these companies.

In addition to the work of the association, individual States are active in bringing the problem to the attention of our senior as well as all citizens. In recent months several commissioners have issued warnings against dealing with unlicensed companies. Also, there has been

a noticeable increase in the cooperation between States in controlling these activities.

Briefly, here are a number of techniques presently being used in Ohio and other States. First of all, the several States have laws which forbid companies or agents from doing business in the State without being licensed. Many of these laws, including the one we have in Ohio, are broad enough to extend this prohibition as including the various news media such as radio, television, newspapers, and nationally circulated magazines.

Also, many States have laws which forbid their own licensed domestic companies to operate illegally in other States of the Union. In this context, cooperation between the States is the method of reaching these companies.

Our technique has been to work out reciprocal agreements with sister States by which each State controls the activities of its own domestic company. Upon complaint that such a company is engaging in illegal acts in another State, the home State commissioner takes action and the activity is stopped.

If further sanctions prove necessary, there is another area wherein departments may cooperate on the basis of statutory authority. The majority of States have passed the Uniform Extradition Act. Section 6 of this act provides in effect that the chief executive of a State may extradite one of his residents for the commission of an act in his State or another State which violates the laws of a third State.

By this law, the officers of an unlicensed company soliciting Ohio residents by mail are subject to extradition by their State of domicile, though they may never have visited Ohio, because their solicitation in Ohio violates our section 3905.42 for which there are criminal penalties under section 3901.99 of the Ohio Revised Code.

Without going into unnecessary detail, I can also state that the trend of court cases in recent years has been toward extending the full faith and credit clause of the Federal Constitution. We fully intend to ask the courts of our sister States to enforce our criminal statutes in this area.

We are sure that you will be encouraged by our progress in dealing with these companies. Another approach to the solution of this problem is to bring it forcefully to the attention of our senior citizens so that they will refuse to patronize these unlicensed companies.

In this connection, we commend the National Senior Citizens' Council for its work with the elderly in urging them to read their policies and to check with their insurance departments concerning the offered coverage and the company doing the advertising.

All State insurance departments maintain a list of duly licensed companies whose forms have been approved by the insurance department and whose claim practices are subject to their jurisdiction.

If the recipient of advertising through the mail will merely check with his State insurance department, the insurance information service in his State, or, perhaps, his local better business bureau, he can quickly determine whether or not the company has been licensed by his State.

A refusal to deal with an unlicensed mail-order company by an increasing number of our citizens, plus continued aggressive use of the weapons at the disposal of State insurance departments, will solve this problem.

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To summarize, the National Association of Insurance Commissioners recognizes that some—I put that word "some" in there on that line—of our older citizens have been victimized by the deceptive practice of a few unlicensed mail-order insurance companies.

In our view, the solution is a combination of public education and continued aggressive, cooperative effort by the members of the National Association of Insurance Commissioners as a body and as individuals.

Your letter refers to the use of "health insurance as bait for other services or products." We are unaware of the use of health insurance for such purposes, but perhaps the statements by others at this hearing will indicate whether there is a problem of that type.

It is sincerely hoped, Mr. Chairman, that the foregoing will be of assistance to you and your subcommittee. We appreciate the opportunity to present our views during this hearing.

Appendix A has a list of the various States having laws that have been spoken of in the first part of this statement.

My State is not mentioned there but I would like to add that Virginia has these laws, too. We have all of those that are mentioned in here and we do our best to see that they are enforced.

(The appendix referred to follows:)

(Text continues on p. 102.)

APPENDIX A. STATUTES REGULATING INSURANCE ADVERTISING ADOPTED IN THE VARIOUS STATES

In this appendix, an attempt has been made to collect and describe the statutes of each State bearing on insurance advertising. For each State, the treatment is divided into two parts:

(1) An analysis of the language of the Model Fair Trade Practices Act (referred to herein as the "model act") as adopted in each State with reference to those variants of language which might affect its applicability to unlicensed insurers. Principally, these are provisions governing service of process, venue requirements and availability of an appropriate penalty. Where the model act fails to provide specific authority, further reference has been made to the general law of the State.

(2) A collection of the substantive provisions of other statutes in each State which deal with insurance advertising. In general, such statutes are criminal in character and provide as penalties imprisonment as well as fines. References to statutes in force in virtually every State which prohibit, with criminal penalties, false advertising in general, are omitted.

Alabama.—(1) Model act adopted in 1957, as Alabama statutes, title 28, section 90; permits service of process by mail (sec. 90(6)); venue in any county (sec. 90 (8)); provides for fines (sec. 90(11)).

(2) Other acts which regulate insurance advertising: title 14, section 211—prohibits deceptive advertising; title 28, section 26 and section 28 forbid advertising that misrepresents terms of policies.

Alaska.—(1) Model act adopted in 1957. Alaska compiled laws, sections 42–5–1 et seq.; act does not specify method of serving process and omits venue provisions. General process section, section 55–4–8, permits service by publication in actions against unauthorized insurers that arise within the State.

Arizona.—(1) Model act adopted in 1954 as Arizona revised statutes sections 20–441 et seq. Act does not specify method of service. By section 20–403, director of insurance is agent for service of process on unlicensed insurer; by rule 4(d) of the rules of civil procedure, unlicensed corporations may be served by publication.

(2) Other acts: Section 20–1110—insurance director may require filing and approval of advertising; section 20–1111—director shall disapprove a policy, or withdraw previous approval, "If purchase of such policy is being solicited by deceptive advertising," "* * * [D]irector may disapprove any advertising which is in violation of this title"; section 44–1481—prohibits advertisements "containing any false, fraudulent, deceptive, or misleading representations."

Arkansas.—(1) Model act adopted 1949 as Arkansas Code sections 66–3001 et seq.; permits service of process by mail (sec. 3007(e)); venue in Pulaski County chancery court (sec. 3009); provides fines (sec. 3012).

California.—(1) Model act adopted 1959 as California Insurance Code, sections 790,000 et seq.; review by writ of mandate in any court of competent jurisdiction (sec. 790.05 by reference to government code, sec. 11523, which refers to secs. 1085, 1094, of Code of Civil Procedure); provides fines (sec. 790.07). Act does not specify method of process; California government code section 11505 provides for service by mail of accusation in agency hearing where agency regulations require respondent to file his address; California corporation law section 6501 permits service on secretary of state in actions against unlicensed corporations.

(2) Other acts: Insurance Code section 704—prohibits fraudulent conduct of business by an insurer; section 780—prohibits misrepresentations, by insurers, officers, agents, brokers, or solicitors, as to the terms of a policy, its benefits or privileges, or its future dividends; section 781—prohibits any person from misrepresenting a policy for the purpose of inducing a person to purchase the policy; "twisting" and unfair or incomplete comparisons of policies.

Colorado.—(1) Model act enacted 1949 as Colorado revised statutes sections 72–15–1 et seq.; permits service of process by mail (sec. 72–15–6(5)); venue in district court of Denver County (sec. 72–15–8); provides fines (sec. 72–1–31).

(2) Other acts: Section 40–15–1—prohibits any advertisement which contains "any assertion, representation or statement which is untrue, deceptive or misleading;" Section 72–7–29—prohibits agent making "false or fraudulent statement or representation in, or with reference to, any application for insurance * * *;" section 72–3–16—forbids insurance companies or officers or agents misrepresenting "the terms of any policy issued * * * or the benefits or advantages promised thereby, or the dividends or shares of surplus to be received thereon, or (the use of) any name or title of any policy or class of policy misrepresenting the true nature thereof."

Connecticut.—(1) Model act adopted 1955 as Connecticut revised statute section 38–1 et seq. Venue provisions appear in section 38–62(c) and specify Hartford County; act provides fines (sec. 38–62(e)). No special provision is made for service of process. Section 52–59a permits service on secretary of state in actions against unlicensed corporations arising from business transacted in State.

(2) Other acts: Section 38–55 prohibits incomplete comparisons of policies by any company or person to induce surrender or lapse; section 38–56—prohibits advertisements by insurers as to funds or assets not actually possessed and available for the payment of losses; section 38–57—requires that insurance company advertisements showing assets shall, "with equal conspicuousness, give its liabilities;" section 38–365—prohibits any advertisement or statement "containing any assertion (which is) * * * untrue, deceptive, or misleading."

Delaware.—(1) Model act enacted 1955 as Delaware Code, section 531 et seq. Act provides no special venue or means of serving process; by general corporation law, title 8, section 353, substitute service against unauthorized corporation is provided.

(2) Other acts: Section 534—prohibits an insurance company, officer, director, agent, broker, or solicitor from using any advertisement or making any statement which represents the terms, benefits, title, or dividends of a policy.

District of Columbia.—(1) Model act not yet adopted; misleading advertising is prohibited by District of Columbia Code section 35–405 et seq. By sections 35–423–1327, an insurance company acting in the District without a license appoints the insurance commissioner agent for process.

(2) Other acts: section 22–1411—prohibits any "false, untrue, or misleading statement, representation, or advertisement;" section 35–409—prohibits insurers advertising any funds or assets not actually possessed and available for the payment of losses; section 35–714—prohibits an insurance company or its agent using any advertisement or making any statement which misrepresents the terms, benefits, or dividends to be received, or from using any name or title of any policy so as to misrepresent the true nature thereof.

Florida.—(1) Model act adopted 1947 as Florida statute section 643.00 et seq.; service of process by mail (sec. 643.06(5)); venue in Leon County (sec. 643.06(4)); provides fines (sec. 643.11).

(2) Other acts: Section 625.21—provides that an insurer, officer, director, agent, broker, or solicitor shall not issue or circulate any written or oral statement misrepresenting the benefits, privileges, or dividends of a policy nor any incomplete comparison of policies; section 817.06—provides that no person shall use an advertisement which contains any "assertion, representation or statement which is untrue, deceptive, or misleading."

Georgia.—(1) Model act adopted 1950 as Georgia Code, sections 56–401a et seq.; service of process by mail (sec. 56–406a); venue by certiorari in Fulton County (secs. 55–409a–410a); provides fines (sec. 56–411a).

(2) Other acts: section 56–519—prohibits making or causing to be made any "fraudulent or false representations" as to the nature or benefits of an insurance policy; section 56–1310—prohibits misrepresentation of the terms, benefits, or advantages of a policy by a company or agent.

Hawaii.—(1) Model act reenacted 1955 by session laws of 1955, act 277; no venue or special method of service is set forth. Hawaii statutes title 28, section 230–40 permits service of process upon the State treasurer in actions against unlicensed corporations.

Idaho.—(1) Model act enacted 1959 by session laws of 1959, chapter 174, provides for service by mail or publication (sec. 13(5)); venue is in Ada County (sec. 15); provides fines (sec. 18).

(2) Other acts: Section 41–1202—requires every advertisement by an insurer showing its financial condition must correspond with or include its last verified statement made to the department; secion 41–1204—forbids an insurance company or any other person to issue or use any statement or circular "misrepresenting the terms of any policy issued or to be issued by such company, or misrepresenting the benefits or privileges promised under any such policy or the dividend or share of the surplus to be received thereon;" section 41–1205 prohibits twisting.

Illinois.—(1) Model act adopted 1959 as Illinois annotated statutes, chapter 73, sections 1028–41; no special method of service is set forth; venue is in Sangamon County or county where insurer resides or has its principal office (sec. 1019); provides fines (sec. 1038).

(2) Other acts: Chapter 73, section 759 forbids advertisements by an insurer of assets not actually owned available for the payment of losses and claims; section 760—prohibits advertisements by an insurer showing its financial standing in figures "unless the figures exhibited in such advertisement correspond to the figures contained in the next preceding verified statement made to the director" and unless certain minimum financial data are set forth; section 761 contains lengthy, detailed, and extensive limitations upon insurance advertising. It prohibits misrepresentation as to the terms of a policy, its benefits or advantages, or estimates of the dividends to be received thereon; the use of any name or title of a policy misrepresenting its nature; twisting; false or malicious statements calculated to injure a competitor; misrepresentation as to financial condition.

Indiana.—(1) Model act adopted 1947 as Indiana statutes annotated, sections 39–5301 et seq.; permits service by mail (sec. 39–5305(f)(2)); venue is in Marion County (sec. 39–5307); provides fines (sec. 39–5312).

(2) Other acts: Section 10–2114—forbids advertising one's self as agent of an insurer which has not complied with legal requirements as to capital and assets; section 10–2115—forbids advertising one's self as an agent of "any fictitions or spurious insurance company"; section 10–2125—forbids dissemination of false advertising by U.S. mail and other specified media; section 39–5019—prohibits insurer advertising funds in excess of those actually owned and available for the payment of losses and claims.

Iowa.—(1) Model act adopted 1955 as Iowa Code annotated sections 507B.1 et seq.; provides for service by mail (sec. 507.B.6); venue in Polk County (sec. 507.B.8; provides fines (sec. 507B.11).

(2) Other acts: Section 506.2—provides: "Before the commissioner of insurance shall issue such certificate of compliance (required by sec. 506.1 and before a domestic insurer can solicit or sell stock or membership commissioner must first be satisfied as to) * * * the character of the advertising to be used * * *"; section 511.22—provides that no insurance company may "advertise or publish an authorized capital, or * * * represent in any manner itself as possessed of any greater capital than that actually paid up and invested."

Kansas.—(1) Model act 1955 by session law of 1955, chapter 247; provides for services by mail (sec. 6(e)); venue in Shawnee County (sec. 10) or in court of competent jurisdiction (sec. 8) provides fine (sec. 11).

(2) Other acts: Section 40–235—prohibits an insurance company or any agent thereof from using any advertisement which misrepresents the terms, benefits or dividends of a policy.

Kentucky.—(1) Model act adopted 1950 as Kentucky revised statutes sections, 304.924 et seq.; no special procedure for service of process or governing venue. By section 271.610, a corporation which transacts business in Kentucky appoints the secretary of state its agent for the service of process.

Louisiana.—(1) Model act adopted 1948 as Louisiana Revised Statutes, title 22, sections 1211–17; provides for service by mail (sec. 1354) or by publication (sec. 1354); venue in East Baton Rouge Parish (sec. 1360).

(2) Other acts: Section 212(7)—requires that a policy contain a prominent statement of the renewal terms and provides that the insured may return the policy and receive a refund of premiums within 10 days if the policy was solicited by untrue, deceptive, or misleading statements; section 621(5)—provides that the commissioner of insurance shall disapprove a policy or withdraw previous approval of it, "if purchase of insurance thereunder is being solicited by deceptive advertising"; section 1523 forbids advertisements in any form "setting forth the advantages of or soliciting business for any insurer which has not been authorized to do business in Louisiana."

Maine.—(1) Model act enacted 1949 as Revised Statutes of Maine, chapter 60, sections 146 et seq.; provides far service by mail (sec. 151); venue in Kennebec County (sec. 153); provides fines (sec. 157).

Maryland.—(1) Model act enacted in 1947 as Maryland Annotated Code, article 48A, sections 346 et seq.; provides for service by mail (sec. 351(e)); venue is in county of residence (sec. 353(a)); provides fines (sec. 357). Article 23, section 95(b), provides that where the corporation has no local principal place of business, venue is in plaintiff's county.

(2) Other acts: Article 48A, section 54, makes it unlawful for any person to advertise, by any medium, "the advantages of or soliciting business for any insurance company * * * which * * * has not been authorized to do business in this State."

Massachusetts.—(1) Model act enacted in 1947 as Massachusetts General Laws Annotated, chapter 176D, section 1–14; provides for service by mail (sec. 6); review in supreme judicial court (sec. 8); provides fines (sec. 11).

(2) Other acts: Chapter 175, section 181, prohibits companies, officers, agents, brokers, and advisers from making or using any statement "misrepresenting the terms of any policy * * * or the benefits or privileges promised thereunder * * * or any * * * incomplete or misleading comparison of any such policy * * * with any other such policy * * *"; section 191 provides that the commissioner of insurance "may require a company to submit for his inspection * * * copies of any * * * circular or other advertising matter issued by it in the Commonwealth."

Michigan.—(1) Model act enacted in 1947 as Michigan Compiled Laws, sections 500.2001 et seq.; provides for service by mail (sec. 500.2034); venue in Ingham County (sec. 500.2032); provides fines (sec. 500.2040).

(2) Other acts: Section 500.2055 prohibits insurance company advertisements which "falsely represent or hold out to the public that the capital stock of such company is greater than its actual amount," or which otherwise misrepresent the financial condition of the company; section 500.2057 prohibits insurance companies issuing "any false or misleading advertisement * * * or * * * representations * * * tending to conceal or misrepresent the true identity of the issuer or insurance company which is carrying the liability under any policy issued in this State"; section 514.7 prohibits misrepresentations or incomplete comparisons of insurance policies.

Minnesota.—(1) Model act enacted in 1947 as Minnesota Statutes Annotated, section 72.20 et seq.; provides for service by mail (sec. 712.25(5)); venue in Ramsey County (sec. 72.27); provides fines (sec. 72.31).

(2) Other acts: Section 60.48 requires an insurance company to "display all * * * advertisements * * * in its own corporate name" and, when publishing its assets, to publish its liabilities "with equal conspicuousness * * *"; section 61.10 prohibits misrepresentation as to the terms, benefits, advantages, or future dividends of a policy, and the use of misleading titles upon policies. Violations are punishable by revocation of the company's license.

Mississippi.—(1) Model act adopted in 1956 as Mississippi Code, sections 5649–01 et seq.; provides for service by mail (sec. 5649–06); venue in Hinds County (sec. 5649–08); provides fines (sec. 5649–11).

(2) Other acts: Section 5634 requires that when an insurance company advertises its assets, "it shall in the same connection and with equal conspicuousness publish its liabilities * * *"; section 5683 prohibits any person from knowingly or willfully making "any false or fraudulent statement or representation in or with reference to any publication for insurance * * *."

Missouri.—(1) Model act adopted in 1959 as Missouri Statutes Annotated, sections 375.930 et seq.; provides for service by mail (sec. 375.940(5)); provides fines (sec. 375.946); by general venue statute, any person aggrieved by commission order may have review in Cole County (sec. 536.110(3)).

(2) Other acts: Section 375.240(3) requires an insurance company advertising its assets to advertise its liabilities "equally conspicuously," and limits advertisements of capital to that actually paid up in cash; section 376.590 prohibits life insurance companies, officers, directors, and agents from issuing any circular or statement misrepresenting the terms of a policy, its benefits, advantages, or future dividends, or the use of any policy title or name misrepresenting the true nature thereof.

Montana.—(1) Model act adopted in 1959 by session laws of 1959, chapter 286 (effective Jan. 1, 1961); venue in Lewis and Clark County (sec. 44); provides fines (sec. 216(3)). There is no special provision for service of process. Section 93–3008, which deals with civil procedure, now provides that personal jurisdiction of an unauthorized corporation in causes of action arising within the State may be obtained by serving the secretary of state.

(2) Other acts: Montana Revised Statutes, section 40.1425, requires that agency advertisements give the location of the company and the State in which it is organized; section 40.1939 provides that no life insurance company or any other person shall issue any circular or statement "misrepresenting the terms, benefits, or advantages of any policy issued by any such corporation."

Nevada.—(1) Model act adopted in 1949 as Nevada Revised Statutes, sections 686.390 et seq., Nevada in 1957 enacted the Unauthorized Insurers False Advertising Process Act, sections 686.480–686.500, which specifies a procedure for obtaining jurisdiction of unauthorized insurers in regulatory proceedings and makes certain substantive provisions of the insurance law specifically applicable to such insurers.

(2) Other acts: Section 686.150 prohibits an insurance company, officer, director, agent, clerk, broker, employee, or any other person from making, issuing, or using any advertisement or statement which misrepresents the terms, benefits, or advantages of a policy, using a title which misrepresents the nature of the policy, or twisting.

New Hampshire.—(1) Model act adopted 1947 as New Hampshire Revised Statutes Annotated, sections 417.1 et seq.; provides for service by mail (sec. 417.9); appeal lies to supreme court (sec. 417.11 by reference to sec. 541); provides fines (sec. 417.13).

New Jersey.—(1) Model act adopted in 1947 as New Jersey Statutes Annotated (secs. 17:29B–1 et seq.; provides for service by mail (sec. 17:29B–6(e)); venue in superior court (sec. 17:29B–8); provides fines (sec. 17:29B–11).

(2) Other acts: Section 2A:117–1 forbids a life insurance company from advertising that it has funds or assets "not actually possessed by it and available for the payment of losses and claims and held for the protection of its certificate holders or creditors" misrepresentation of the terms, benefits, advantages or future dividends of a policy, the use of a policy title which misrepresents its true nature, or twisting; section 17:18–10 provides that if an insurance company advertises its assets, it must advertise its liabilities "equally conspicuously"; section 17:34–21 prohibits any insurance company from issuing any statements misrepresenting the terms, advantages, or future dividends of a policy, or using any policy title which misrepresents its true nature; section 17:38–1 prohibits advertisements of an accident or health policy containing "misleading or inadequate description."

New Mexico.—(1) Model act adopted in 1947 as New Mexico Statutes, sections 58–9–9 et seq.; provides for service by mail (sec. 58–9–14); venue in Santa Fe County (sec. 58–9–16); provides fines (sec. 58–9–17).

(2) Other acts: Section 58–11–2 provides that the superintendent of insurance may withdraw approval of any policy form if it is being solicited by "deceptive or misleading" advertising.

New York.—(1) Model act adopted in 1948 as New York insurance law sections 270–282; review is in accordance with customary procedures for administrative determinations (sec. 277, 279); provides fines (sec. 280). No special provision is made for service of commission process, except by reference to section 22 which permits service by mail.

(2) Other acts: Insurance law, section 97, requires insurance company advertisements of its financial condition to show its admitted assets, liabilities, reserves, and surplus, and requires that such advertisement correspond with the next preceding verified statement to the superintendent; it provides detailed definitions and descriptions of permissible content for financial advertisements by insurance companies and prohibits advertisements by an insurance company that "it has, or expects to have, reinsurance by any named assuming insurer not authorized to do such reinsurance business in this State, or to the

effect that its policies are guaranteed wholly or partly by any other person, insurer, or institution"; section 126 prohibits advertisements which do not conform to section 97, above, or which "call attention to any unauthorized insurer or insurers" and requires advertisements which refer to an insurer to provide the company's name in full and the city in which it has its principal office; section 127 prohibits misleading statements and incomplete comparisons of policies by an insurer, agent, broker, or representative of any insurer authorized to transact business in New York; section 211 prohibits misrepresentation and incomplete comparison of policies; penal law, section 1203 makes it a misdemeanor for an insurance corporation or agent to issue or circulate "any illustration, circular, or statement indicating that such corporation can transact in this State any business of a character other than that which it is authorized to transact under the certificate of authority issued to it by the superintendent of insurance. * * *"

North Carolina.—(1) Model act adopted in 1949 as North Carolina General Statutes, sections 58–54.1 et seq; provides for service by mail (sec. 58–54.6); venue in Wake County (sec. 58–54.8); provides fines (sec. 58–54.1).

(2) Other acts: section 14–117 prohibits any "untrue, deceptive, or misleading" advertisement; section 58–34 provides that when any insurance company advertises its assets. "it must in the same connection and with equal conspicuousness publish its liabilities" and the published capital must be limited to that "actually paid in cash"; section 58–49 provides that if any agent or other person "shall knowingly or willfully make any false or fraudulent statement or representation in or with reference to any application for insurance * * *," he shall be guilty of a misdemeanor; section 58–54.4(9) requires that when the details of a policy's benefits are set forth in advertisement, the major exceptions must also be set forth; also that if the policy is renewable at the option of the company, or cancelable by the company, the advertisement must contain a clear reference to the renewal or cancellation terms.

North Dakota.—(1) Model act adopted in 1957 by North Dakota laws of 1957, chapter 204, section 1–12; provides for service by mail (sec. 6(e)); venue in Burleigh County (sec. 8); as to undefined acts, only venue provided is county of respondent's residence (sec. 9); provides fines (sec. 11). By session laws of 1951, chapter 188, North Dakota enacted a statute establishing specific procedures for obtaining jurisdiction of unauthorized insurers and subjecting their advertising to regulation. This act is sections 20–09A01–09A07 of the revised code.

(2) Other acts: section 26–1011 prohibits misrepresentation of the terms, benefits, or dividends of a policy; section 26–1012 prohibits twisting.

Ohio.—(1) Model act adopted in 1955 as Ohio Revised Code Annotated, sections 3901.17 et seq.; provides for service by mail (sec. 3901.17(B)); venue in Franklin County (sec. 3901.17); provides for cease-and-desist order (sec. 3901.22).

(2) Other acts: Section 3905.43 provides that no person shall publish or distribute "any advertising matter in which insurance business is solicited, unless such advertiser has complied with the laws of this State regulating the business of insurance * * *"; section 3923.16 provides that no insurer, agent, or broker shall use advertising which is "materially misleading or deceptive"; the superintendent may suspend or revoke a license for willful violation of an order to cease and desist; sections 3911.23 and 3999.08 prohibit an insurance advertisement which misrepresents the terms, benefits, advantages, or future dividends of a policy, and forbids use of a policy title which misrepresents the true nature thereof; they also forbid twisting; section 3999.10 forbids an insurance company advertisement which represents funds or assets as in its possession when they are not actually possessed by the company and available for losses and claims; also forbids advertising subscribed capital not actually paid up in cash; section 3999.11 forbids life insurance company financial advertisements at variance "with the last preceding verified statement made by it to the insurance department of any State."

Oklahoma.—(1) Model act adopted in 1955 as Oklahoma Statutes Annotated, title 36, sections 1201 et seq.; provides for service by mail (sec. 1206(e)); venue in any county (sec. 1208); provides fines (sec. 1211).

(2) Other acts: Title 36, section 4506, prohibits any advertisement misrepresenting the terms and benefits of an insurance policy or the use of a policy title misrepresenting the true nature thereof.

Oregon.—(1) The model act has not been adopted, but Oregon Revised Statutes, section 736.708, prohibits insurance advertising containing "untrue, deceptive, or misleading" advertising, for which section 736.990 provides fines. Other pertinent

sections regulatory of deceptive advertising are section 646.810 (general prohibition on deceptive advertising); and section 736.605 (which prohibits misrepresentation of assets in insurance advertising. The insurance prohibitions are regulated in an administrative context and sanctioned by cease-and-desist orders (sec. 736.608(2)). The sections which govern insurance advertising do not distinguish between licensed and unlicensed insurers and do not provide any special means of serving process. By section 736.210(5), if a corporation does business in the State and fails to appoint an agent, service can be accomplished in actions growing out of such in-State business by serving the State insurance commissioner; section 57.700 permits service upon the corporation commission and in actions or proceedings against an unauthorized corporation based on their activities with the State.

Pennsylvania.—(1) Model act adopted in 1947 as Pennsylvania Statutes Annotated, title 40, sections 1151 et seq.; for venue, refers to administrative agency law, section 1710.41 which specifies Dauphin County (sec. 1158); rules 2076–80 of the rules of civil procedure permit service by mail on nonresidents. Model act provides for fines (sec. 1159).

(2) Other acts: Title 18, section 4857, forbids advertisements on behalf of an insurance company not authorized to do business in Pennsylvania; title 40, section 236, makes it a misdemeanor to advertise oneself as an agent of an insurance company "which has not complied with the laws of this State * * *"; section 237 makes it a misdemeanor to advertise the sale of insurance for or on behalf of a spurious, nonexistent, or inactive insurance company; section 277 prohibits misrepresentation of the terms or benefits of a policy by an insurance company, broker, or solicitor; section 278 prohibits twisting; section 472 prohibits issuance by an agent of written or oral statements misrepresenting the terms or future dividends of a policy.

Rhode Island.—(1) Model act adopted in 1958 as Rhode Island General Laws, sections 27–29–1 et seq.; provides for service by mail (sec. 27–29–5(d)); venue in Providence County (sec. 27–29–7); provides civil fine (sec. 27–29–9).

(2) Other acts: section 27–4–5 prohibits a life insurance company from misrepresenting the terms, benefits, and advantages of any policy and from making incomplete comparisons between policies for purposes of twisting.

South Carolina.—(1) Model act enacted in 1947 as South Carolina Code, sections 37–1201 et seq.; provides for service by mail (sec. 37–1209); venue in Richland County (sec. 32–1212); provides fine (sec. 37–1221).

(2) Other acts: Section 37–144 prohibits life insurance companies and agents from using advertisements which misrepresent the terms, benefits, advantages and future dividends of a policy or from using a policy title which misrepresents the true nature thereof; section 37–144.1 prohibits twisting; section 37–471 provides for withdrawal of approval of policy forms being solicited by means of misleading or deceptive advertising.

South Dakota.—(1) Model act enacted in 1947 by South Dakota, session laws of 1947, chapter 144; read in conjunction with session laws of 1945, chapter 136, provides for service by customary means of the "call and demand order." The original process; all other regulatory process may be served by mail; no special venue provision is included; act provides fines. South Dakota Statutes Annotated, section 33.0811 provides that unauthorized foreign corporations may be served by mail in causes of action arising in the State.

(2) Other acts: Section 31.1103 prohibits an insurance company, officer, director, solicitor, agent, or broker from misrepresenting the terms, benefits, advantages, or future dividends of any policy, or using a policy name or title which misrepresents the true nature thereof, or twisting.

Tennessee.—(1) Model act enacted in 1947 as Tennessee Code Annotated, sections 56–1201 et seq.; provides for service by mail (sec. 56–1206); venue is in chancery court in county where respondent resides or does business (sec. 56–1208); provides fines (sec. 56–1209). Section 48–912 provides that venue in actions against unauthorized corporations may be in the county where the cause arises. Section 16–617(4), which controls venue in chancery courts, provides that actions may be brought in the county where the cause of action arises.

(2) Other acts: Section 56–712 prohibits advertising by any person in behalf of any foreign insurance company which has not fully complied with the insurance title of the Tennessee Code; section 56–1219 forbids life insurance companies, officers, directors, or agents from misrepresenting the terms, conditions, character, benefits, advantages, or future dividends of a policy, or using a policy title which misrepresents the true nature thereof. Violations are punishable, by reason of section 56–139, by a fine of up to $500.

Texas.—(1) Model act enacted in 1957 as Texas Annotated Statute Insurance Code, article 21.21 et seq.; provides for service by mail (sec. 6 (e)); venue in Travis County (sec. 7(b)); provides fines (sec. 10).

(2) Other acts: Insurance Code, article 21.20 provides that no life insurance company, officer, director or agent shall misrepresent the terms, benefits, advantages, or future dividends of any policy; Penal Code, article 580b provides that no insurer shall misrepresent the terms, benefits, advantages, or future dividends of any policy issued by it, or use a misleading title or a policy, or engage in twisting; article 1554 forbids advertisements containing "any assertion, representation or statement of fact which is * * * untrue, deceptive or misleading * * *."

Utah.—(1) Model act adopted in 1947 as Utah Code Annotated, sections 31–3–9–10, 31–27–1 et seq.; no special provision is made for venue or service of process; Utah Rules of Civil Procedure, rule 4(e), (f), permits service by publication in actions against unauthorized foreign corporations.

(2) Other acts: Section 31–7–15 prohibits misrepresentation of the terms benefits, advantages or future dividends of any policy, or the use of misleading policy titles, or twisting; section 31–19–10 provides that the insurance commissioner may disapprove or withdraw approval of any insurance form "if purchase of insurance thereunder is being solicited by deceptive advertising"; section 31–27–3 forbids filing or making an inaccurate statement of an insurer's financial condition; section 31–27–4 forbids "any false, deceptive, or misleading representation relative to the business of insurance * * *"; section 31–27–7 requires insurer advertisements regarding financial condition to correspond with the last verified statement filed with the commissioner, and prohibits advertising assets not "actually owned and possessed by the insurer in its own exclusive right * * *"; section 31–27–9 forbids misrepresentation of the terms, benefits, advantages or future dividends of a policy, or the use of misleading policy titles; section 31–27–18 forbids twisting.

Vermont.—(1) Model act adopted in 1955 as Vermont Statutes Annotated, title 8, sections 4721 et seq.; provides for service by mail (sec. 4730); venue in Washington County (sec. 4733), by reference to sec. 4088); provides fines (sec. 4737).

(2) Other acts: Title 8, section 4084 prohibits the use of misleading or deceptive advertising by any insurance company, agent or broker; if the insurance commissioner finds advertising or a plan of solicitation to be materially misleading, he shall issue a cease and desist order; section 4736 prohibits insurance advertisements which misrepresent the financial condition of a company, the terms or benefits or privileges of a policy, and twisting.

Washington.—(1) Model act adopted in 1947 as Washington Revenue Code, sections 48.30.010 et seq.; provides for service by mail (sec. 48.30.010(5)); or publication (sec. 48.04.040); venue is in Thurston County (sec. 48.04.100); violations of the insurance law are punishable by fine (sec. 48.01.080).

(2) Other acts: Section 48.30.030 forbids publication of an inaccurate statement of an insurer's financial condition; section 48.30.040 forbids "false, deceptive or misleading" insurance advertisements; section 48.30.050 requires all insurance advertisements to show the full name and location of the insurer's home office in the United States if an alien insurer; section 48.30.070 requires financial advertisements of an insurer to "correspond with the insurer's last verified statement," and requires that an advertisement of assets be limited to those "actually owned and possessed by the insurer * * *"; section 48.30.090 forbids misrepresentation of the terms, benefits, advantages or future dividends of a policy, or the use of a misleading policy title; section 48.30.180 forbids twisting.

West Virginia.—(1) Model act adopted in 1955 and reenacted in 1957 as Insurance Code, article 11, section 3472; provides for service by mail (sec. 3472(73)); venue in Kanawha County (sec. 3472(75) by reference to sec. 3294(13)); provides fines (sec. 3472(78)).

Wisconsin.—(1) Model act adopted in 1947 as Wisconsin Statutes Annotated, sections 207.01 et seq.; provides for service by mail (sec. 207.06(5)); venue in Dane County (sec. 227.15, 227.16); provides fines (sec. 207.11).

(2) Other acts: Section 201.45 requires advertisements of insurance companies as to "financial standing" to show the "capital actually paid in" and amount of net surplus over liabilities correspond to last verified statement made to the insurance department; limits advertising as to assets to those "actually possessed and available for the payment of losses and held for the protection of policyholders"; section 201.46 prohibits misrepresentation as to the type of risks written by a company; section 201.53(13) prohibits misrepresentation by an insurance company, officer, or agent.

Wyoming.—(1) Model act adopted in 1955 as Wyoming Statutes Annotated, sections 26–155 et seq.; provides for service by mail (sec. 26–160(e)); venue in Laramie County (sec. 26–164); provides fines (sec. 26–163).

(Text continued from p. 94.)

Senator WILLIAMS. Thank you very much, Mr. Parker. We appreciate your appearing for the association.

I just wanted to make one observation and ask one question:

Earlier witnesses—I believe you were here—indicated that insurance commissioners and State insurance commissions cannot reach the active test in the health service area where the program is not insurance but health services.

Did you hear that?

Mr. PARKER. Yes; I heard that.

I was surprised because I think in most of the States now the service organizations do come under the regulation of the insurance department. They do in my State and we recently passed that act, too, by the way, only about 4 years ago.

They put them under certain controls. There are certain things we cannot do, but they are regulated by my department.

Senator WILLIAMS. We would like to have the opportunity to address written questions to the association for a written reply for the record.

Mr. PARKER. I think that would be all right, sir.

Senator WILLIAMS. We appreciate very much——

Mr. PARKER. You understand this is not my statement.

Senator WILLIAMS. I recognize that. Thank you very much.

We will recess until 2 o'clock.

(Whereupon, at 12:57 p.m., the committee was recessed, to reconvene at 2 p.m. the same day.)

AFTER RECESS

(The subcommittee reconvened at 2 p.m., Senator Harrison A. Williams, Jr., chairman of the subcommittee, presiding.)

Chairman WILLIAMS. The committee will be in order.

Our first witness this afternoon is Mr. Walter Rountree, general council, office of the State treasurer, Tallahassee, Fla. He will present the statement of J. Edwin Larson, state treasurer and insurance commissioner of the State of Florida.

I gather you combine these functions as we do in New Jersey, banking and insurance.

Mr. ROUNTREE. That is right, Senator.

STATEMENT OF J. EDWIN LARSON, STATE TREASURER AND INSURANCE COMMISSIONER, STATE OF FLORIDA, AS PRESENTED BY WALTER E. ROUNTREE, GENERAL COUNSEL, OFFICE OF THE STATE TREASURER, TALLAHASSEE, FLA.; ACCOMPANIED BY FRANK ALEXANDER, CHIEF OF THE ADMINISTRATIVE DEPARTMENT, OFFICE OF THE STATE TREASURER, TALLAHASSEE, FLA.

Mr. ROUNTREE. My name is Walter Rountree. I am general counsel for the Insurance Department of Florida. The statement that I am giving here today is the statement of the insurance commissioner, the Honorable J. Edwin Larson. Due to the short notice we had, relative

to your meeting, the commissioner could not be here personally and asked me to represent him, which I am very happy to do.

Before I present the commissioner's statement, I would like to introduce Mr. Frank Alexander, who is chief of our administrative department, relative to this subject matter that we are here discussing today.

If you are following me from the statement that has been furnished, I will omit the first paragraph, because that relates to Mr. Larson himself. Picking up at the second paragraph:

(Text continues on p. 105.)

Providing health insurance for the over 65 has generated much interest in Government and industry circles. One of the first approaches by the industry to handle this on a mass basis was the well-known Connecticut 65 plan, wherein a number of companies agreed to provide coverage under a pool type for all persons over 65. Massachusetts followed with a similar plan.

Before the Massachusetts plan became active, however, I directed members of my staff to do a complete study of the existing Connecticut plan and the Massachusetts plan. We held discussions with the Insurance Department of Connecticut and the officials of the Connecticut companies shortly after their first enrollment period. We met several times with the Health and Welfare Interim Committee of the Florida Legislature. Senator Harrell, who is chairman of the committee, has been and is deeply concerned with the health needs of our older people. We also met with our Florida domestic companies. After due consideration and examination of all information, we decided that a pool-type plan similar to Connecticut and Massachusetts would not be the proper course to follow in Florida.

One of the reasons behind this was the sprawling geographical area of this State as compared to the smaller States of Connecticut and Massachusetts where the over-65 could be reached more completely. Another was that the growth of insurance in Florida has been so rapid that all available skilled technicians to administer such a program are absorbed and needed in the management of our own domestic companies.

Later at a joint meeting of the Florida Insurance Department together with Senator Herrell's health and welfare legislative committee and representatives of the industry, I suggested that we sponsor an amendment to our licensing laws so that all agents qualified to sell accident and health insurance could offer over 65 coverage for any company without obtaining an additional license. Whereupon, representatives of several of the large out-of-State companies admitted to do business in this State promised that if we could arrange to have available the entire agency force selling accident and health coverages, they in turn, would offer coverages on persons over 65 without regard to their health and would provide various programs according to their needs and their ability to pay.

Subsequently, the agents' licensing laws were amended by the 1963 legislature whereby a qualified accident and health agent, without further licensing, could sell such insurance for any company authorized in the State.

It was our belief that many companies did have available excellent plans of health insurance with varying degrees of underwriting and benefits that would fulfill the needs of the over-65. We also felt that other companies were anxious to enter this field. As a result, we contacted by mail every company licensed to do business in Florida explaining that we were setting up a senior citizens division so as to advise our citizens of the availability of this coverage. We also urged each company to forward to us ample specimen copies of policies, brochures, and rates, which they did. There are now 77 companies participating in our program.

We gave special training to 1 man in each of our 20 field offices throughout the State and designated him the senior citizens adviser of his area.

During the past 15 years we have established 20 field offices in the most strategic areas of the State to carry out the responsibilities of the insurance commissioner as outlined in Florida law and to bring the services of the insurance department to the people at the local level. These field offices provided the facilities on which we could launch our senior citizens service program.

Each of these advisers keeps an up-to-date listing of the companies which offer this type of coverage, plus sample policies, brochures, and rates, so that persons over 65 and their families may study the forms and determine what coverage fits their needs.

It should be noted here that each of these policies provides a reasonable guarantee of renewability. We believe this is essential for persons in this age group. Under such a guarantee no one person could be singled out for a change in benefits or an increase of premium, and so forth, without the same change being made on all policyholders in this State of that class. Neither can any company discontinue any contract on a policyholder without discontinuing all contracts in the State. Many are guaranteed renewable for life.

Policy benefits vary greatly so that a person may obtain high benefits if he so desires. The underwriting requirements of the companies also vary; however, many will accept impaired risks. Policy forms are carefully screened by one of the department's specialists who has had 17 years experience with the insurance department in the examination of policy forms for approval or disapproval in accordance with our standard policy provision laws. All advertising is checked to determine if it conforms with our rules and regulations on accident and health advertising so as to avoid misleading or deceptive advertising material.

One of the duties of the staff members in the various offices is to point out to all persons the importance of the application for insurance which becomes a part of the contract and one of the considerations for the issuance of the contract. The reason for this is that we have found that most complaints arise from the lack of knowledge of the policyholder as to benefits and to incomplete and inaccurate applications.

We also have five area supervisors who are highly trained and experienced in the accident and health field. Most of them came to us from the industry. These area supervisors act in a liaison capacity between the field offices, the Tallahassee office, and the various civic and professional organizations on a statewide basis. Since our program was inaugurated last summer these advisers have brought the message of our senior citizens service to over 300 groups, including civic groups, agents' associations, and senior citizens' organizations. Personal information and advice has been given to thousands of people at these meetings as well as in the field offices.

During this time there have been four open periods by several companies whereby, in line with our new accident and health licensing law, all people over 65 were offered the opportunity to cover themselves or for a person to cover his parents regardless of their health history.

The companies holding these open enrollment periods, and some are just now completing theirs, have reported excellent response. In fact, at least one open enrollment was extended to accommodate all who wanted to purchase this insurance.

No doubt, from time to time, there will be additional enrollments by the various companies under this group approach plan, and, of course, all the companies participating in our senior citizens plan will continue to offer excellent individual coverage at reasonable prices.

We are grateful for the wholehearted cooperation and active support received from our Florida companies, the out-of-State companies doing business in Florida, and all of our Florida agents; associations. It is worthy to mention that during the open enrollment periods every agents' association in the State distributed the material to their members in order that they, if they were qualified and so desired, could offer this coverage to their over-65 clients and especially to those who were impaired. This meant that during the period from March 15 to April 30, 1964, over 8,000 Florida agents, under the amended agents' qualification law, were able to offer this coverage for 2 companies to people 65 years old and over.

We are aware of the problems of unlicensed mail-order insurance solicitation as over the years the Florida Department of Insurance has issued bulletins warning the citizens of Florida of this type of insurance and urging them to buy from licensed companies and licensed agents which come under the jurisdiction of the insurance commissioner.

In fact, at the June 1963 meeting in Seattle of the National Association of Insurance Commissioners, the NAIC adopted a resolution regarding unfair and deceptive advertising of mail-order insurance, and I quote:

"Where an insurance commissioner receives such a complaint about an insurance company that is not licensed in his State, such complaint should be referred to the insurance commissioner of the State in which the company is domiciled. In any such case, where the insurance commissioner of the State of domicile fails within a reasonable time to advise the referring commissioner that appropriate steps have been taken to eliminate recurrence of the use of any improper advertising involved in the case, the referring commissioner should trans-

mit a copy of the material involved to the FTC and send an information copy to the NAIC."

We felt that Florida's increasing number of older citizens could be fertile grounds for such mail-order activity. We also felt that if these senior citizens were adequately informed of the availability of health insurance and could receive counseling and advice locally there would be no desire for them to obtain coverage from an unlicensed company which would not come under the supervision of the insurance department.

Our program has not been in existence long enough to compile statistics as to the actual number of persons insured, but we do know that the response and interest has been even greater than we anticipated. We also know that we have received many inquiries not only from these senior citizens, but also from other States as well.

According to a study recently completed at the University of Florida, the number of persons 65 years of age and older increased in Florida by 133 percent between 1950 and 1960 compared with a national average of 35 percent. More are moving in weekly and it has been estimated that here are in excess of 600,000 over 65 residing in Florida at the present time. However, a large number are retirees who prearranged to live their retirement years in our State with varying degrees of financial security. This of course increases Florida's percentage of senior citizens who are able to purchase health insurance according to their needs.

We believe, therefore, that our method of helping these over 65, through the facilities of our senior citizens services, secure adequate insurance at a reasonable cost, in conjunction with the Kerr-Mills bill, will enable all persons in the State who are in this age category to obtain the protection which they need and deserve.

I want to thank this committee for the interest it has taken in our program. If we can be of any further assistance, we will be delighted to respond to your wishes.

Respectfully submitted.

J. EDWIN LARSON,
State Treasurer and Insurance Commissioner.

Mr. ORIOL. Mr. Rountree, Senator Williams had to leave for another quorum call. Perhaps we can continue with a few questions until he gets back.

You have already described a very comprehensive State program. We wondered if there was any immediate cause and a special need for this kind of program. Do you feel that the senior citizens need such a program?

Mr. ROUNTREE. Yes; we do, Mr. Oriol. It was recognized by the commissioner well over a year ago and that is why he established within his field offices these special divisions so that these elderly people would have a place to go to have full disclosure made to them as to what they were purchasing.

There can be little doubt that many of our senior citizens have been taken advantage of by mail-order houses and this advertising. It was Commissioner Larson's feeling that a full disclosure was not being made to them. He inaugurated this program, held these meetings personally throughout Florida, gave them wide publicity and so if a senior citizen of Florida today reads an ad soliciting sale of insurance, all he has to do is contact one of our field officers, where it will be analyzed and he will be given a full disclosure of what he is purchasing.

Mr. ORIOL. Among the people using the services now, does there appear to be a fairly typical complaint? What seems to be the source of confusion?

Mr. ROUNTREE. Actually, when you treat it fairly on what the facts are, I would say that much or a majority of it is due to a misunderstanding in the application itself. In other words, they simply, in

making the application and in the representations to them, have a misunderstanding at that point. In other words, the average person feels that he has more benefits than what the policy actually provides. That was not explained properly or there was an improper explanation at the time the application was taken.

Mr. ORIOL. Is there any requirement with reference to fine print?

Mr. ROUNTREE. In Florida, under our laws, with reference to the policy itself and the application, it must be 10 point, I believe it is.

Now we have heard a lot about small print. In Florida that has been eliminated. Any exception in the policy must be in the same type as the benefits provided. So we, like I say, have eliminated from the standpoint of fine print, misunderstanding on that, because it does not exist in Florida.

Mr. ORIOL. Under this program, has there been any attempt at standardization of application forms?

Mr. ROUNTREE. I am going to ask Mr. Alexander to assist on some of this, because he has developed it, but the answer to that question is "No."

Mr. ALEXANDER. There would be no attempt to standardize the applications, because the applications are according to the companies' needs and the amount of benefits that they are supplying. If you are going to buy an exceedingly large amount of insurance, the application is much more extensive than it is if you are going to buy a small amount of insurance. If you go to a bank and borrow $100,000, you have more forms to fill out than if you go to a bank to borrow $10.

Mr. ORIOL. I wondered if there was any attempt to show any special clauses.

Mr. ALEXANDER. The application asks the man's name, address, his occupation, his health history, and who is his doctor. That is standard for all companies which gives the company information from which to determine whether or not the man is an acceptable risk for the contract being offered.

Mr. ORIOL. You mention on page 5, that you received "wholehearted cooperation" from out-of-State companies. How are they helping you with this program?

Mr. ROUNTREE. By making their facilities available under the program. That is what we are referring to there. Some of the big, more responsible companies have come forward to assist in this program and are making their facilities available to it.

Mr. ORIOL. Senator Nye, do you have any questions at this point?

You mention this resolution adopted by the NAIC on June 1963.

Mr. ROUNTREE. Yes, sir.

Mr. ORIOL. I wonder if you could take us through this sort of step by step?

What happens to an out-of-State company, unlicensed to do business in another State in any such case, "where the insurance commissioner of the State of domicile fails within a reasonable time to advise the referring commissioner that appropriate steps have been taken to eliminate recurrence of the use of any improper advertising involved in the case, the referring commissioner should transmit a copy of the material involved to the FTC and send an information copy to the NAIC." What would be the procedure then? What would happen then and how would this help overcome the difficulty?

Mr. ALEXANDER. When we would receive a complaint on advertising, or it would come to our attention that an out-of-State company was putting out advertising material distributed into Florida that we thought was misleading or misrepresenting, we would send a copy of that with the letter of protest to the home State, which has not occurred yet. We have had no complaints or seen any advertisements that were misleading come into Florida that have come to our attention.

We cannot see all that come into Florida, but they are sent to us by the public and also our offices watch for them and our agents watch for them. But the procedure would be to send them to the home State. The same is true when we have a claim arise on a company not licensed in Florida. We send that to the home State and ask the home State insurance commissioner to give us full information and report back to us. Then we, in turn, go to the policy in Florida and explain the circumstances or coverage or uncoverage and how his claim was settled.

Mr. ORIOL. You would depend pretty much on cooperation and exchange?

Mr. ALEXANDER. That is right, cooperation and exchange of information. But if we sent an advertising piece off and did not hear from them, then we would send it as outlined in the resolution to the NAIC.

Mr. ORIOL. Is there any way that the FTC might be able to give you more useful information on this?

Mr. ROUNTREE. Let me explain that, Mr. Oriol, a little further. We were happy to collaborate with the FTC in the preparation of their guides, submitted this morning. Now Florida, I believe, was the third or fourth State in the Nation to adopt those guides as rules of the Florida Insurance Department. You heard the man representing the FTC state that the only procedure they had was in connection with proceedings of cease and desist. That may be true, but Florida has adopted their guides and rules, and those become a part of the policy form itself. So if a company submits their policy form for approval, their method of sale is considered a part of that. If a domestic company, meaning one, of course, organized in Florida, offers for sale or attempts to offer for sale—and they are required to make a full disclosure to us—in States where they are not authorized to sell, it then will not be approved in Florida and so they naturally cannot proceed.

To answer your question specifically, we have also had the best of relations with the FTC. We have adopted their guide as the laws of Florida and we use it whenever it becomes necessary.

(The guide referred to follows:)

TREASURER'S OFFICE,
STATE OF FLORIDA,
Tallahassee.

DEAR SENIOR CITIZEN: The need for health insurance for senior citizens, at a reasonable cost, has been of considerable concern to me for some time.

After a 2-year study of the problem, I am pleased to announce the establishment of a senior citizens services division within the framework of the insurance department as outlined in the following pages.

With the tools now at our disposal, we believe this new service will best serve you. To this end, the insurance business in Florida has given its support and cooperation, for which we are most grateful.

The purpose of the senior citizens services division is to help you. Please do not hesitate to call on us.

Yours sincerely,

J. EDWIN LARSON,
State Treasurer and Insurance Commissioner.

SENIOR CITIZENS SERVICES DIVISION

The Senior Citizens Services Division of the Florida Insurance Department was established by J. Edwin Larson, State treasurer and insurance commissioner, to assist Florida's senior citizens in obtaining adequate health insurance coverage.

The U.S. census reports indicate that there are now in excess of 600,000 men and women age 65 and older in Florida. In addition, Florida has a higher percentage of persons in this age group than any other State in the Nation because of our climate, recreational facilities, and reasonable living costs.

Even though health insurance premiums in Florida increased from $25 million in 1950 to $181 million in 1962, many of our senior citizens do not have hospitalization, surgical, and medical coverage.

An accident and health specialist in the Tallahassee office of the insurance department coordinates the program of the senior citizens services division. A trained and experienced accident and health deputy is located in each of the 19 field offices to serve the senior citizens of his area. These deputies work closely with the central office in Tallahassee. Five area advisers act as liaisons between the field offices, the Tallahassee office, and various civic and professional organizations on a statewide basis.

The senior citizens services division has contacted all insurance companies authorized to write accident and health insurance in this State. More than 70 companies now offer health insurance contracts to our over 65 population, all with a reasonable guarantee of renewability.

A special file is maintained in the Tallahassee office and each of the 19 field offices, containing specimen policies, brochures, and rates of each of the companies offering such insurance. The files are kept up to date as additional companies and contracts become available and are valuable sources of information for the benefit of senior citizens.

During the 1963 legislature, a bill was sponsored and enacted, which allows any agent licensed to sell health insurance for one company, with the consent of the company, to write health insurance on people 65 and over and their spouses, regardless of age, for another company without being required to obtain an additional license. This enables the agent to secure adequate health coverage more readily for people over 65 even though his principal company may not have this facility.

The senior citizens services division has available a list of those licensed companies offering over 65 health contracts. They also have the names of all insurance companies licensed in Florida which come under the jurisdiction of the insurance commissioner. Advice to policyholders as to the benefits and provisions of their policies is another service provided.

Senior citizens may visit, phone, or write the nearest field office listed on the back of this leaflet for any assistance that is needed with their health insurance problems.

Chairman WILLIAMS. We very much appreciate your statement, Mr. Rountree. I had to run out briefly to answer a rollcall over there, but I will certainly review your testimony.

Mr. ROUNTREE. Just get in touch with us. We will be here at any time.

Chairman WILLIAMS. Thank you very much, sir.

Our next witness is Mr. Sherwood Colburn of Detroit, Mich., who is the former insurance commissioner of Michigan.

We welcome you and look forward to your statement.

STATEMENT OF SHERWOOD COLBURN, PARTNER, INSURANCE FIRM OF BARON, COLBURN & COLBURN, DETROIT, MICH.

Mr. COLBURN. Mr. Chairman, members of the committee, I unequivocably endorse this timely action by the U.S. Senate in extending their interest and deep concern in the area of frauds and misrepresentations affecting the elderly citizens of our Nation.

The manifestation of my interest emanates from my roles as an interested citizen, an active and proud member of the insurance industry and my experiences as a former State insurance commissioner

and as a past member of the National Association of Insurance Commissioners.

I am in complete accord with the basic philosophy of State regulation of the insurance industry; however, I do not subscribe to the belief that ineffectual regulation by the various States should be awarded immunity from a responsible reevaluation by the U.S. Senate.

One of the most widespread, persistent, tragic, and almost uncontrollable problems which has confronted the Michigan Department of Insurance for all too many years has been the high-powered sales pitches designed to sell completely inadequate and totally misrepresented health insurance policies to the elderly.

These irresponsible huckster approaches have taken the forms of:

1. Wholesale mail order solicitation which emanates from insurers who are not licensed nor authorized to conduct their business in the State.

2. Intensive and dramatic newspaper advertising by these same unlicensed insurers; and

3. The employment of specially-trained one-shot interview "con" artists whose object is to "hit and run." While representing but a small segment of the licensed insurance carriers, these "gangs" descend upon preselected target communities—often rural—as well as other areas with a preponderance of older residents. Their bag of tricks includes completely fraudulent comparisons of their policy with that which may be presently held. Far too often past medical history is completely ignored or glossed over by the unscrupulous agent in completing the insurance application to the later distress of the individual who thought he was purchasing coverage.

I have several items here that I would like to take up and, therefore, depart from my prepared text. This is a press release from the Michigan Department of Insurance of March 16, 1962. I would like to have this made a part of the hearings, and would just like to quote two or three sentences from the entire press release.

The Michigan Department of Insurance has recently received numerous inquiries and complaints concerning the activities of the [blank] company, an unathorized and unlicensed insurer in this State which is engaged in the active mail solicitation of the parents and wives of recent inductees into the Armed Forces.

According to departmental records, this company is licensed to do business only in the State of Arizona and its activities in Michigan are clearly in violation of statutory law.

Unauthorized companies, by soliciting business here, often sell policies which do not contain uniform provisions required by Michigan law to protect policyholders and misrepresent the benefits in advertising brochures. Further, they are not subject to regulation by the Michigan Department of Insurance nor can the financial condition of such unlicensed companies be independently determined by Michigan authorities.

This was in March of 1962.

Another example of this type of press release is one from the Michigan Department of Insurance, dated December 13, 1962.

Because of the frequency with which elderly citizens are becoming the targets for high-powered "pitches" sent through the mail by unlicensed insurance companies, State Insurance Commissioner Sherwood Colburn today issued this special warning to them:

"Watch out for out-of-State insurance offers, particularly those descibing low cost, no examination coverage for medical and hospital care for persons past age 60.

"Michigan Insurance Department records show that many policyholders frequently have difficulty in obtaining satisfactory settlements of claims against unlicensed insurers.

"In the case of licensed insurers, State law empowers the insurance department to assure their fair treatment of policyholders and settlement of claims in accordance with contract terms.

"The lure of fabulous coverage for pennies may be tempting, but, unless the company is licensed by the Michigan Department of Insurance, your policy may be worthless."

Again, in May of 1962 in an address to the annual meeting of the Michigan State Association of Life Underwriters, I would like to read two or three important quotes and I would like this also to be made a part of this proceeding.

* * * prospects and clients seem to be confused by all the deals available—not to mention the gimmicks of the not-so-professional insurance agent. I maintain that the day of the insurance peddlers is long past. I have asked groups and associations to rid their ranks of the gimmicker, the peddler, the unethical. To these groups and associations I have said: "Strengthen your bylaws, enforce and maintain the highest standards of ethics."

This particular paragraph was in reference to the responsibilities that the agents' associations and the agents and brokers themselves have if they are to help bring about professionalism in their business.

Further in my speech, while discussing the insurance industry as a whole, I stated:

The biggest cry these days and for the past many years, has been Federal intrusion and Federal regulation.

Continuing, I said:

When, or when, will the sleeping giant again yawn? Will it only be after State regulation has gone down the drain, or am I flattering the same segments of industry by thinking that even Federal regulation could make them yawn, let alone wake up to the realities of the 20th century?

During that speech in May of 1962: I said:

Wholesale mail order solicitation of life insurance by companies not licensed in Michigan is becoming more of a problem each day. The State seems to be flooded by all kinds and types of mail order solicitation, mostly for limited-type coverage. We have also noticed a marked increase in newspaper advertising incorporating the use of companies not licensed to do business in the State of Michigan. It would be most helpful if the newspapers in the State of Michigan would only accept advertising from those companies licensed to do business in Michigan; most certainly it would be in the public interest. And along this line, the Department is sending a letter to each and every newspaper in the State of Michigan, asking that they only accept advertising from licensed Michigan companies. This letter will be mailed within the next few days.

I have had three meetings with Frank J. Kelley, attorney general for the State of Michigan, with reference to mail solicitation, by unauthorized insurers, and it was agreed by both Mr. Kelley and myself that until such time as the Federal Government or the National Association of Insurance Commissioners do come up with some overall solution, that we can take the following steps:

1. A model letter was drafted and signed jointly by both myself and Attorney General Kelley in response to all inquiries regarding unauthorized companies. This letter clearly sets forth the position of our department and the attorney general's office that we can accept no responsibility for the licensing or supervision of these companies, being careful, however, not to recommend cancellation. These letters are being sent out almost daily.

2. A model letter setting forth the facts has been drafted and will be sent to various associations throughout the State in hope that they will sponsor and absorb the cost of running advertisements in various newspapers, particularly in the Detroit area.

3. We intend to look closely into and analyze the volume and types of inquiries received by both this office so that strong letters can be sent to those companies

posting the most serious problems in our State, with copies of such letters being sent to the particular States' Governors and attorneys general, and to the National Association of Insurance Commissioners.

The Michigan department of Insurance has on several occasions issued press releases stressing the point of doing business with only licensed and authorized life insurance companies, agents, and solicitors in view of the tremendous efforts being put forth by unlicensed and unauthorized out-of-State insurers who have been flooding the direct mail market and also using local newspapers and magazines for promotion schemes. We shall continue to issue press releases. We shall continue to work with Attorney General Kelley. We shall continue to fight with everything in our power against the activities of these unlicensed and unauthorized companies.

In conclusion, I would like to make one short statement pertaining to one of the biggest, if not the biggest, challenges that your industry faces today—presentation of State regulation.

Public Law 15 (the McCarran Act) simply says:

"Unless the various States regulate the insurance business, then the Federal Government will."

Another problem just as serious as unlicensed direct mail-order and newspaper advertising are these "gangs" of whom I have previously referred to, who represent a very small segment of the licensed insurance community. They can keep an entire insurance department busy keeping up with their activities.

They descend on all areas, particularly those with a high percentage of elderly people, and conveniently leave out past medical history in the application forms. In some instances they hear of past medical history from the elderly applicant. However, they do not put it into the application. In other instances, they do not even bother to ask. They automatically write no, no, no, no, or they might say to somebody, "Well, a little ulcer condition such as the one you are talking about has no bearing on our company's underwriting attitude.

I have always violently opposed what I call postclaim underwriting. They start underwriting these insurance contracts at the time of the loss. The underwriting should take place when the application is submitted to that company. In a memo from my staff I quote:

We have found that the limitations with respect to preexisting conditions are a continuing problem, insofar as claim settlements are concerned, primarily because the insureds are not aware of the restrictions imposed upon them by preexisting limitations.

At that time I wanted to place a large overprint on the policy explaining preexisting conditions and limitations. Furthermore, I wanted a statement signed by the insured upon delivery of that policy to the point that he understood that preexisting conditions could conceivably interfere with a claim settlement. Once a person has this full knowledge then I think we have a fair and equitable situation between the insured, the agent, and the company.

We further determined that another solution would be to block out the medical history questions in the application. I feel that the medical history portion of every single health and accident insurance application should be answered in the handwriting of the applicant with each answer initialed. In that way we would be able to avoid some of the activities of the unscrupulous insurance agent. It was determined that we would discuss this approach with members of the health insurance industry.

We did. I would like to quote from a staff memo:

Industry people were reluctant to accept our recommendations both from a cost standpoint and also that our approach was detrimental to the business.

They did suggest that we consider the policy of adopting a 10-day prelook requirement which is in effect in many States and that the policy be accompanied with some written statements from the company to the effect that this policy should be reviewed thoroughly for accuracy.

I think that the problems that exist in Michigan exist in the very same States that have the 10-day free look. There is no doubt that the elderly person has a specific problem when it comes to health insurance. I have one case in mind that I call the Saginaw case. I had accepted an engagement in 1963 to address the Saginaw Association of Life Underwriters in Saginaw, Mich. Two members of the Michigan department, enforcement division, were accompanying me on this trip, and we determined that we would take two or three files with us, so that in the event we had some spare time, we could do a little fieldwork.

We went to one home and here we found a retired couple. He was 74 years of age. He had been approached by a Borax operator and was sold on dropping his Blue Cross-Blue Shield. He was convinced by this "sharpie" that he was getting more for less.

Now this man had a history of diabetes and had suffered a stroke. He told the agent of this past medical history. The new policy was still issued. Several months later, the insured had a leg amputated as a result of his diabetes condition. Within 1 month he had a second stroke. Bills from these two claims totaled over $3,500. Both claims were rejected by the X company. The reasons were twofold, preexisting conditions and that he had withheld important medical information from the company. We contacted the agent. He was no longer in the business. We corresponded with the company. We had no reaction from this company other than the fact that there were no claims. We called an officer of the company into our office. In the middle of our negotiations with this company to settle this claim, the insured passed away. We were finally able to get his widow $2,000 which actually reflected what Blue Cross-Blue Shield would have paid under their policy.

Senator WILLIAMS. Who paid that?

Mr. COLBURN. The company that originally denied the claims. We told them, sir, that in our opinion their actions and activities made our department question just how much longer the citizens of Michigan could have faith and confidence in their company. Now they did pay the claim. But certainly an insurance department cannot sit back and take on these activities daily. Why is the older American such an irresistible target for these unscrupulous promoters?

1. Most of the avenues to the better commercial insurers are blocked to the elderly. Extraordinarily high annual premiums, benefit limitations, and in many instances the inability on the part of the older person to meet the minimum physical requirements effectively serve as barriers to the better insurance policies.

2. Coupled with this is the fact that older people often have poor medical histories and are subject to a variety of chronic illnesses which necessitate expensive care on a recurrent basis.

3. The desperate need for insurance protection, born from the two factors previously mentioned, along with their reduced incomes, force the aged to seek and embrace almost any insurance policy offered. Even those who have sacrificed to retain fairly decent policies are lured by the siren song of claims hailing "low cost, no exam, compre-

hensive hospital and medical coverage, no ifs, ands, or buts, no limitations * * * all for pennies a day." In many instances this come-on is gilded with the phrase: "Only 25 cents for the first month." And far too often these people tragically abandon higher cost, but most certainly higher benefit protection.

In Michigan, there are some 650,000 citizens over the age of 65. And, for example, the average annual income of an older person in that State, living alone or with nonrelatives, is only $1,010.

These problems which I have outlined are not peculiar to nor unique to Michigan. I dare say they occur in every State in the Union. This is a serious national problem, and one that has occupied the attention of the National Association of Insurance Commissioners since 1888. Many proposals have been made to the NAIC to curb the harmful practices of such insurers in order to protect all citizens in every State, but all too few proposals have been implemented.

A well-respected insurance publication, Probe, which comes out weekly, in volume 11, No. 3, dated February 10, 1964, had this to say:

And while we're on the subject of legislation, isn't it about time that the State departments were given the right to prohibit the mail solicitation and sale of life insurance by companies not licensed in those States? It's almost laughable to adopt expensive and elaborate procedures to protect the citizens of a State against unqualified companies, and at the same time to permit some out-of-State shyster outfit to flood the mails with application forms.

The Michigan Association of Insurance Agents in December of 1963 in a release entitled "Mail-Order Insurance" had this to say:

Even the holiday season provides no relief from mail-order solicitation by unlicensed insurance companies. Some newspaper, radio, and television stations continue to accept advertising from unlicensed insurers despite previous appeals of Michigan Insurance Commissioners and attorneys general that this not be done.

Inconsistent as it seems, States are virtually powerless to control use of the Federal mails. Congressional action to bar use of the mails to unlicensed companies was once supported by your association, but the effort failed in deference to a few old and reputable firms which have always operated in this fashion.

Advertising contracts between unlicensed carriers and news media are invariably consummated through the mails. It is indeed questionable if the States can forbid such negotiations or those for insurance by a citizen with an unlicensed company. Enforcement problems under these conditions concerning the terms of policy or even free insurance currently publicized are virtually impossible.

I have here an editorial from the National Underwriters which is entitled "Unlicensed Insurers." I will not read the entire editorial; however, I want it made a part of the record, and I would like to point out just a couple of interesting thoughts that are expressed here.

About all the insurance departments can do when the shaky, nonlicensed insurer floods several States with advertising and direct-mail promotion is to warn the people of their States of doing business with a company from which it may be difficult to collect in case of a claim. Hampering such a company legally is as difficult as trying to collect water in a net.

(The editorial is as follows:)

UNLICENSED INSURERS

Protecting the public against the dishonest or dubious insurer must be one of the least-relished jobs of a State insurance department. In the first place, most people are unaware of this function of their State insurance authorities. The national activities of the Pure Food and Drug Administration in safeguarding the consumer are well known, but the corresponding insurance protection by the States is less publicized. In the second place, insurance has so thoroughly sold

itself to the public by its high standard of performance that the unscrupulous are able to trade upon a tremendous fund of goodwill. Furthermore, many reputable insurance companies use direct-mail promotion extensively, and the shady operator can slip his in with the rest; some of the unlicensed insurers with bucketshop operations have impressive-sounding names. And a nonlicensed insurer who operates by mail is not necessarily fraudulent, only likely to be an unwise choice for the buyer.

WARN THE PEOPLE

About all the insurance departments can do when the shaky, nonlicensed insurer floods several States with advertising and direct-mail promotion is to warn the people of their States against doing business with a company from which it may be difficult to collect in case of a claim. Hampering such a company legally is as difficult as trying to collect water in a net.

The best protection for the policyholder is to continue to deal with an agent he can trust. Fortunately for the public, most buyers of insurance do just that. Furthermore, the agent or broker should be prepared to furnish information about insurers his clients may ask about. He should be ready to tell whether the company is licensed in the State and something about its financial stability. In some cases this information is not in standard books of reference, and this omission is the most damning fact that can be ascertained about any except a very new company. Confidence in the informed agent will help protect the policyholder more than any other single factor.

Mr. COLBURN. I have before me a letter which is part of a continuing program concerning frauds affecting consumers in the State of Michigan. This program is conducted by Attorney General Frank J. Kelley. This letter is called insurance by mail.

The attorney general names 11 companies and their addresses in this release. This was back in 1962.

(The letter is as follows:)

(NOTE.—This is one in a series of articles by Frank J. Kelley, State attorney general, concerning frauds affecting the consumers of this State.)

INSURANCE BY MAIL

Unlicensed foreign insurance companies are the source of numerous complaints from Michigan consumers who, after responding to attractive newspaper advertisements placed by out-of-State insurance companies, discover too late that the coverage is not what they thought it would be; and that because the insurance company is not registered with the State of Michigan, State authorities can offer no quick and painless remedy.

When challenged, continued Attorney General Kelley, these foreign insurance companies who are not authorized to do business in Michigan, usually reply that they are operating entirely in interstate commerce and, therefore, are beyond the reach of any State officer or department in Michigan. Fortunately, development of case law doctrines on "doing business" within the last few years have brought many out-of-State operations within the reach of State control. Despite this fact, it is the experience of my consumer protection division that Michigan citizens who purchase insurance from these companies do so in the belief and expectation that they are fully protected by the authority of the State insurance department. Since this is not the case, I am asking the division to review with the department of insurance the present status of all such complaints, and develop a plan for bringing this problem under control. Meantime, I am taking this opportunity to report to the people of Michigan that they will be wise to check with the State insurance department and with the consumer protection division before investing in insurance advertised by an out-of-State insurance company, no matter how attractive the advertisement.

Among those unlicensed foreign insurance companies concerning which complaints have recently been received are the following:

Prudential Life & Casualty Co., Oklahoma City 18, Okla.
Peerless Life Insurance Co., Automobile Owners Division, 434 South Wabash Avenue, Chicago 5, Ill.
Automobile Owner's Association, Inc., 2632 McGee Street, Kansas City 8, Mo.

National Protective Life Insurance Co., Hammond, Ind. Also: 434 South Wabash Avenue, Chicago 5, Ill.
Guarantee Reserve Life Insurance Co., Hammond, Ind.
Standard Life & Accident Co., Auto Owners Division, 434 South Wabash Avenue, Chicago 5, Ill.
First National Life Insurance Co. of America, 2632 McGee Street, Kansas City 8, Mo.
Time Life Insurance Co., San Antonio 8, Tex.
New Empire Co., Kansas City, Mo.
Old American Insurance Co., Kansas City, Mo.
The National Bellas-Hess Life Insurance Co., 715 Armour Road, North Kansas City 12, Mo.

Mr. COLBURN. Here is a copy of a letter sent to every newspaper in the State of Michigan in which we stated:

In the public interest, we ask your assistance and unreserved cooperation with our efforts to eliminate improper solicitation of insurance in Michigan by unlicensed and unauthorized companies, for the protection of the consuming public, the communications media, and the legitimate insurance community.

(The letter is as follows:)

STATE OF MICHIGAN,
December 18, 1962.

DEAR SIR: The increasing volume of newspaper advertisements by unauthorized and unlicensed insurance companies now appearing in Michigan newspapers has become a matter of grave concern to the Michigan Department of Insurance and the attorney general of Michigan.

Review of the records of the attorney general's consumer protection division and of the department of insurance indicates numerous inquiries and complaints of nonpayment of claims, deceptive advertising, fraudulent misrepresentation, or failure to abide by contract, on the part of some of the unlicensed foreign insurance companies now soliciting business in this State by direct mail and newspaper advertising. Many of these companies are not able to meet the financial and other requirements of doing business in Michigan.

Where companies have been licensed by the State, the department of insurance can protect both the companies and the public by enforcing the licensing and regulatory requirements of Michigan law. But where the company complained of has not been licensed in Michigan, the State authorities have no responsibility for and no power to supervise its operation. In cases of criminal fraud or violation of State law, the attorney general can and will take remedial action. But the day-by-day policing and protection of policies and policyholders which the Michigan public counts on and looks to the State to provide is not available where the insurance company has not complied with the requirements of the licensing law. The State cannot bear full responsibility for the soundness or honesty of the contracts of the unlicensed foreign insurance company. The customer must look elsewhere for protection. For this reason, we need your help.

The Michigan Press Association is continually advised of all new companies licensed and all company withdrawals in this State. Should there be any question as to the status of any foreign insurance company with respect to its Michigan license, we suggest that you inquire at the office of the Michigan Press Association or at the Michigan Department of Insurance, Lewis Cass Building, Lansing 13, Mich.

In the public interest, we ask your assistance and unreserved cooperation with our efforts to eliminate improper solicitation of insurance in Michigan by unlicensed and unauthorized companies, for the protection of the consuming public, the communications media, and the legitimate insurance community.

Your acknowledgment, review, and comments on this letter will be most helpful. We hopefully anticipate your cooperation.

Yours sincerely,

FRANK J. KELLY,
Attorney General.
SHERWOOD COLBURN,
Commissioner of Insurance.

Mr. COLBURN. Now I would like to say here and now that the newspapers of the State of Michigan were extremely cooperative. We have

what we would like to consider a rather outstanding example. Here is—

a statement of policy regarding insurance advertising from the Detroit Free Press * * * in the best interests of the public.

(The matter referred to is as follows:)

"IN THE BEST INTERESTS OF THE PUBLIC * * * AND IN YOUR BEST INTERESTS AS WELL * * * THIS DEPARTMENT IS MOST GRATEFUL * * *"

A statement of policy regarding insurance advertising from the Detroit Free Press

STATE OF MICHIGAN,
DEPARTMENT OF INSURANCE,
Lansing, Mich., February 22, 1963.

Mr. CYRIL M. BROWN,
National Advertising Manager,
The Detroit Free Press,
Detroit, Mich.

DEAR MR. BROWN: This will acknowledge and thank you for your letter of February 13, 1963, advising that the Free Press will not accept any advertising on behalf of any foreign insurance company that is not licensed or authorized by this department to do business in this State.

Needless to say, this department is most grateful to you and the management of the Detroit Free Press for the assistance and cooperation. This cooperation and the attitude which you have displayed in assisting the department is to be commended. I am so advising Commissioner Colburn.

In addition we appreciate your willingness to advise this department if at any future time your management reexamines or decides to deviate from the present policy.

In accordance with your request I have mailed to Al Gabeline five copies of the commissioner's most recent annual report together with subsequent changes.

Thank you again for your help.

Cordially yours,

JOHN W. FAUNCE,
Deputy Commissioner.

The Detroit Free Press has a responsibility to its readers and its advertisers. That is the responsibility to see that the advertising appearing in its pages is placed by companies that are of substantial stature and real reliability.

From that sense of responsibility comes this policy regarding insurance advertising:

"The Free Press will not accept any advertising on behalf of any insurance company that is not licensed or authorized by the Michigan Department of Insurance to do business in the State of Michigan."

Because we believe this policy is as important to you as it is to our readers, we take this opportunity to make it known to you.

To implement it, a list of the licensed and authorized insurance companies is supplied the Free Press by the insurance commissioner's office at regular intervals.

Our readers will benefit by this decision, for they will read the advertising of companies they can depend on, such as yours. You will benefit, because your advertising will not share space and attention with that of unlicensed and unauthorized companies in the insurance field.

THE MORNING FREE PRESS PUTS YOU ON TOP OF THE INSURANCE MARKET

Free Press readers have the purchasing power that makes them prime prospects for insurance of all types.

In Greater Detroit, for instance, 42.5 percent of all Free Press reader families enjoy incomes of $7,000 or more, 83.7 percent of them own their own homes. And these families control 42.7 percent of the total buying power of America's fifth market.

These top of the market families depend on the Free Press for new information, ideas, and advertising. Sixteen different readership studies of Detroit and Michigan executives, over a 20-year span, show the Free Press is the leading newspaper with the executive market.

Leading insurance companies know the importance of the Free Press as a basic advertising medium. Proof: In 1962, the Free Press carried 42.8 percent of the national insurance linage placed in Detroit papers—up from a 39.1 percent share of field the preceding year.

Mr. COLBURN. The Detroit Free Press, a large metropolitan daily did cooperate with us, along with many other papers in the State of Michigan. But this is significant. This is extremely significant because, again, the National Underwriter has an editorial comment entitled "Balking the Unauthorized Insurers".

(The editorial is as follows:)

EDITORIAL COMMENT: BALKING THE UNAUTHORIZED INSURERS

In the good citizen league, some sort of prize should go to the Detroit Free Press for its policy of refusing advertising from insurers not authorized to do business in Michigan. A year ago, at the suggestion of the Michigan department, the Free Press announced that it would adopt this policy, and it has stuck to it, even though its major competitor in Detroit has not adopted such a rule.

So far as the Detroit Life Underwriters Association knows, the Free Press is the only large metropolitan newspaper in the United States to take such a stand, though most of the papers in other cities in the State have adopted the same policy as the Free Press. Nobody has calculated how much it has cost these papers in advertising revenues, but obviously the loss would run to many thousands of dollars.

However, one difficulty has arisen: Many of the newspapers that have taken this enlightened stand are being circumvented because unlicensed companies are advertising in nationally syndicated sections that the papers include with their Sunday editions.

Activities of unlicensed insurers that penetrate a State's barriers have been increasing, and are extremely difficult to thwart. In California the State attorney general has been asked to rule on the legality of such advertising, even without special legislation. In New York State Senator Condon and Assemblyman Russo have identical bills in that would prohibit New York publications, radio stations, and TV broadcasters from carrying advertising of nonauthorized insurers and would make it unlawful for a seller or distributor of magazines to handle out-of-State publications with advertising for unlicensed companies unless the advertisement states in 10-point boldface type that the company is not licensed or authorized to do business in New York State.

When he was insurance commissioner of Michigan, Sherwood Colburn became interested in the problem of newspaper advertising of unlicensed insurers and took the case to the papers. He worked closely with the Michigan Press Association, and now the newspapers usually check with the press association to see if an insurer wishing to advertise is licensed in Michigan.

In addition, Mr. Colburn and the State attorney general made many contacts in the States where the unlicensed advertisers are domiciled, asking them to restrict their activities in sending out mail-order materials to States where they are not licensed. These moves—coupled with a series of press releases blasting the unlicensed advertisers and warning the public of the dangers involved—had some success and are expected to result in still further reduction in the promotion work of unlicensed insurers. Direct mail from some of these companies fell off considerably, as the companies were not getting the expected results from their advertising, the Detroit Life Underwriters Association reports. The association has found that the releases should be sent out at least quarterly.

It is encouraging to know that something effective can be done against unlicensed insurers by (1) enlisting the cooperation of newspapers against taking

their ads, and (2) putting out warnings on the very real handicap that an insured is under when he buys from an unlicensed company. The building up of an intelligent attitude of suspicion toward insurers that won't take the trouble to comply with licensing laws could well make direct-mail and newspaper advertising so much less effective that insurers would have to give it up in those States where such suspicion exists.—R.B.M.

Mr. COLBURN. Now this same interest was shown by many other newspapers in the State of Michigan, radio stations, and television stations. The revenue that they have lost and continue to lose would run into many ten thousands of dollars. However, as they point out in this editorial:

It is encouraging to know that something effective can be done against unlicensed insurers by (1) enlisting the cooperation of newspapers against taking their ads, and (2) putting out warnings on the very real handicap that an insured is under when he buys from an unlicensed company. The building up of an intelligent attitude of suspicion toward insurers that won't take the trouble to comply with licensing laws could well make direct-mail and newspaper advertising so much less effective that insurers would have to give it up in those States where such suspicion exists.

I think that the New York department is looked upon by many in the insurance industry as the so-called epitome of State regulation. In fact, I have even heard it said by some that Federal regulation could never be as stringent as New York regulation. I personally have a great deal of respect for the spirit and philosophy of New York regulation.

Interestingly enough, a bill called the Condon-Russo bill was introduced in the New York Legislature.

This was an act to amend the insurance law in relation to prohibiting advertising media from disseminating in the State advertising from or on behalf of unauthorized insurers and establishing penalties for violation thereof. This, too, I am going to make a part of my statement. But I would like to quote some of the thoughts that are set forth by the New York State Association of Life Underwriters:

The insurance laws of this State are designed to protect the people of this State. * * * Recently, many unauthorized companies have successfully solicited business in New York State by radio station broadcasts, newspaper and magazine advertising. By this means, they have circumvented our protective laws and avoided our insurance department supervision and regulation. The effectiveness of our State laws is being nullified.

This bill would protect the citizens of our State and prevent, in a large measure, policies being bought through the mails and later, disappointed claimants.

The New York insurance law is inadequate to cope with solicitation of insurance on New York State residents by unauthorized insurance companies.

We are an association of 5,600 career life insurance men and women who are licensed by the New York State Insurance Department.

(Text continues on p. 127.)

(The matter referred to is as follows:)

STATE OF NEW YORK

Intro. S. 2551
Print. S. 2676

Intro. A. 4164
Print. A. 4308

SENATE — ASSEMBLY

February 5, 1964

IN SENATE—Introduced by Mr. CONDON—read twice and ordered printed, and when printed to be committed to the Committee on Insurance

IN ASSEMBLY—Introduced by Mr. RUSSO—read once and referred to the Committee on Insurance

AN ACT

To amend the insurance law, in relation to prohibiting advertising media from disseminating in this state advertising from or on behalf of unauthorized insurers and establishing penalties for violation thereof

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The section heading, subsection one and subsection five of section one hundred twelve of the insurance law are hereby amended to read as follows:

Acting for or otherwise aiding unlicensed or unauthorized insurers.

1. *(a)* No person, firm, association or corporation shall in this state act as agent for any insurer which is not licensed or

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

authorized to do an insurance business in this state, in the doing of any business of insurance in this state or in soliciting, negotiating or effectuating any insurance or annuity contract or shall in this state act as insurance broker in soliciting, negotiating or in any way effectuating any insurance or annuity contract of, or in placing risks with, any such insurer, or shall in this state in any way or manner aid any such insurer in effecting any insurance or annuity contract.

(b) No person, firm, association or corporation shall in this state publish, broadcast or televise through any newspaper, magazine, periodical, radio station, television station or other media of public communication any advertisement, public announcement or other notice which directly or indirectly sets forth the advantages of or solicits business for any insurer not licensed or authorized to do business in this state.

(c) No person, firm or corporation shall sell or distribute in this state any newspaper, magazine, periodical, or other written media printed outside of this state which contains any advertisement, public announcement or other notice which directly or indirectly sets forth the advantages of or solicits business for any insurer not licensed or authorized to do business in this state unless such advertisement or other notice shall state conspicuously thereon in bold faced type not smaller than ten point: "Not licensed or authorized to do business in the State of New York"

5. *(a)* Any person, firm, association or corporation violating any provision of this section *except paragraphs (b) and (c) of*

subsection one shall, in addition to any other penalty provided by law, forfeit to the people of the state the sum of five hundred dollars for the first offense, and an additional sum of five hundred dollars for each month during which any such person, firm, association or corporation shall continue to act in violation of this section.

(b) Any person, firm, association or corporation wilfully violating any provision of paragraphs (b) and (c) of subsection one shall, in addition to any other penalty provided by law, forfeit to the people of the state the sum of one thousand dollars for the first offense and two thousand five hundred dollars for each subsequent violation.

§ 2. Subsection one of section one hundred twenty-six of such law, as amended by chapter eight hundred seven of the laws of nineteen hundred forty-one, is hereby amended to read as follows:

1. *(a)* No insurance agent or insurance broker shall make or issue in this state any advertisement, sign, pamphlet, circular, card or other public announcement purporting to make known the financial condition of any insurer, unless the same shall conform to the requirements of section ninety-seven. [No insurance agent, insurance broker or other person, shall, by any advertisement or public announcement in this state, call attention to any unauthorized insurer or insurers.]

(b) No insurance agent, insurance broker or other person, shall in this state cause to be published, printed, distributed, broadcast or televised through any newspaper, magazine, periodical, radio station, television station or other media of pub-

lic communication any advertisement, public announcement or other notice which directly or indirectly calls attention to, sets forth the advantages of or solicits business for any insurer not licensed or authorized to do business in this state.

§ 3. Section one hundred twenty-six of such law is hereby amended by adding thereto a new subsection, to be subsection five, to read as follows:

5. Any insurance agent, insurance broker or other person wilfully violating any provision of paragraph (b) of subsection one shall, in addition to any other penalty provided by law, forfeit to the people of the state the sum of one thousand dollars for the first offense and two thousand five hundred dollars for each subsequent violation.

§ 4. This act shall take effect September first, nineteen hundred sixty-four.

NEW YORK STATE ASSOCIATION OF LIFE UNDERWRITERS, ALBANY, N.Y.

Memorandum in support of senate introduced No. 2551, print No. 2676, by Mr. Condon; assembly introduced No. 4164, print No. 4308, by Mr. Russo, an act to amend the insurance law in relation to prohibiting advertising media from disseminating in this State advertising from or on behalf of unauthorized insurers and establishing penalties for violation thereof

The insurance laws of this State are designed to protect the people of this State. Out of approximately 1,500 life insurance companies in the United States, there are 72 companies domiciled or admitted to do business in New York. Recently, many unauthorized companies have successfully solicited business in New York State by radio station broadcasts, newspaper and magazine advertising. By this means, they have circumvented our protective laws and avoided our insurance department supervision and regulation. The effectiveness of our State laws is being nullified.

This bill would put a penalty on any person, firm, corporation in this State, using a public medium to solicit business for unauthorized insurers. It would, also, set a penalty for any person or corporation selling or distributing in this State any advertisement for an unlicensed insurer unless accompanied by the statement in boldface 10 point type, "Not licensed or authorized to do business in the State of New York."

This bill would protect the citizens of our State and prevent, in a large measure, policies being bought through the mails and later, disappointed claimants.

We urge support of this bill.

NEW YORK STATE ASSOCIATION OF
LIFE UNDERWRITERS,
By SPENCER L. MCCARTHY, C.L.U.,
Managing Director.

MARCH 6, 1964.

NEW YORK STATE ASSOCIATION OF LIFE UNDERWRITERS,
Albany, N.Y., April 6, 1964.

Re memorandum in support of Assemblyman Russo's introduced No. 4164, print No. 4308, an act to amend the insurance law, in relation to prohibiting advertising on behalf of unauthorized insurers and establishing penalties for violation thereof.

Hon. SOL NEIL CORBIN,
Executive Chamber, State Capitol,
Albany, N.Y.

DEAR MR. CORBIN: We are an association of 5,600 career life insurance men and women who are licensed by the New York State Insurance Department to sell authorized insurance policies. We would like to state our reasons why we support this bill.

THE NEED

The New York insurance law is inadequate to cope with solicitation of insurance on New York State residents by unauthorized insurance companies. Insurance is solicited and sold to our citizens in many ways—by mail, by television, by radio, by magazines, and newspapers, as well as by individuals. Only the last is controlled by the present insurance law. Attempts to limit solicitation of unauthorized insurance by advertising media have failed under existing law.

We have given thought to ways other than "limiting solicitations" as a means of curtailing the sale of policies not approved under New York law. We raised the question whether unauthorized insurers are subject to New York State premium taxes because they are "doing business" here. This inquiry was aborted because "doing business" in insurance is related to where the policy is issued or contracted for; and the New York advertising agencies that handle the requests for insurance contend they relay the application and, therefore, are not "doing business."

Likewise, the attempt to bring unauthorized insurers under control by the Federal Trade Commission "misleading advertising" regulations has not been helpful. The New York State Superintendent of Insurance, Thomas Thacher, in a personal interview on this problem with officers of the New York State Association of Life Underwriters in early 1963 expressed the hope that a resolution he was working on for adoption by the National Association of Insurance Commissioners would bring the matter under control. This, too, did not materialize in the way expected; but a substitute effort was made by a joint press release distributed by the Federal Trade Commission and the president of the National Association of Insurance Commissioners on November 6, 1963 (copy attached). The advertisements by nonadmitted companies in local newspapers and radio stations continue in New York State.

THE PRODUCT

We have collected advertisements and several actual policies on New Yorkers issued by unauthorized companies. We have forwarded them to the attorney general and the insurance department. Here is a typical example of the provisions of the policy filed:

	Unauthorized policy	Typical New York State approved policy
Age	69	69.
Premium (total yearly)	$151.26	$106.61.
Death benefit stated	$1,000	$1,000.
Actual death benefit:		
1st 12 months	$250	$1,000.
13th to 24th month	$500	$1,000.
25th month on	$1,000	$1,000.
Plan	Term insurance subject to cancellation by company each month.	Permanent whole life insurance, not cancelable by company.
Dividend	None	As declared. In 1963, amounted to $13.51.

Thus, we find for two-thirds of the years premium ($93.10 versus $151.26) the insured, during the first year, would have four times the coverage ($1,000 versus 25 percent of $1,000) in the approved policy. In addition, the typical

New York admitted company policy is not cancelable; the rate cannot be increased; and the insurance is on the permanent whole life basis with cash values available to the insured. This inferior policy advertised by an unauthorized company was legally purchased in Albany, N.Y., because of the inadequacy of the insurance law. An Albany newspaper in which the advertisement of the unauthorized insurance company appeared, was informed that the company was not licensed to do business in this State. The complaint was referred to the newspaper advertising counsel in New York City where the reply stated that there is nothing in the law to prevent the Albany papers from continuing to accept the advertisements if they choose to do so. They have repeated the advertisements. A similar episode occurred in Watertown, N.Y., after the editor was informed that his paper was promoting an unlicensed company

The insurance department has had this age-69 policy complaint and filing since March 13, 1963. The radio and newspaper advertisements are continuing through March 1964. We conclude that the correction of the problem does not lie with the department, but the insurance law.

SUPPORT OF THE PROPOSED BILL

Paragraph 1(b) of Mr. Russo's bill amending section 112 of the insurance law states:

"No person, firm, association, or corporation shall in this State publish, broadcast, or televise through any newspaper, magazine, periodical, radio station, television station, or other media of public communication any advertisement, public announcement, or other notice which directly or indirectly sets forth the advantages of or solicits business for any insurer not licensed or authorized to do business in this State."

Paragraph 1(c) states:

"No person, firm, or corporation shall sell or distribute in this State any newspaper, magazine, periodical, or other written media printed outside of this State which contains any advertisement, public announcement, or other notice which directly or indirectly sets forth the advantages of or solicits business for any insurer not licensed or authorized to do business in this State unless such advertisement or other notice shall state conspicuously thereon in boldfaced type not smaller than 10 points: 'Not licensed or authorized to do business in the State of New York'."

We believe these provisions—while broad in scope—will correct the condition that now exists; and we ask the Governor's favorable consideration.

SOME FACETS OF OBJECTION TO THE BILL

The objections raised to the bill—largely by those who will be curtailed—may not be applicable.

Objection No. 1.—Reputable, large established insurance companies—doing national advertising—object to being forced to state in 10-point type that they are "not licensed ar authorized to do business in New York State."

Some of these companies would not be affected because they have formed wholly owned subsidiary insurance companies in New York State which would meet the requirements of this law. The parent companies which want to reach the New York market and have been unwilling to modify their method of conducting their business, or their policy premiums, or limit their expenses, or for some other reason have decided not to apply have organized separate New York companies. For example, if the Lincoln National Life Insurance Co. (not authorized in New York State) wanted to advertise in New York State, they would add to their advertisement copy the words, "Lincoln National Life Insurance Co. of New York." This subsidiary and the policies they issue are authorized to do business here.

There are many similar examples as follows:

New York company	*Parent company*
Beneficial National Life Insurance Co.	Beneficial Standard Life Insurance Co.
Companion Life Insurance Co.	Mutual of Omaha
Provident Life & Casualty Insurance Co.	Provident Life & Accident Insurance Co.
State Farm Life & Accident Insurance Co.	State Farm Mutual Automobile Insurance Co. & State Farm Life Insurance Co.

Objection No. 2.—National insurance trade publications which are supported by advertisements from insurance companies not doing business in New York would have to forego this advertising income.

Either by interpretation or by amendment, they would not be affected. It seems clear to those who have been wrestling with this problem for several years that the purpose and intent of this bill is clearly to protect the public. Trade journals are read and subscribed to by sophisticated producers and home office personnel of insurance companies who are not purchasers of the insurance contracts advertised. It is, therefore, perfectly reasonable for the insurance department personnel to interpret this bill as not applying to trade journals. If legal objections are raised, they can be resolved by a subsequent amendment excluding trade journals, without depriving the people of our State the protection afforded by this bill in the meantime.

Objection No. 3.—Magazines like the Reader's Digest, published in Pleasantville, N.Y., would be harmed by a loss of advertising revenue if they had to refuse advertising copy from insurance companies doing business elsewhere, but not licensed in New York State.

We secured a copy of the advertising rate card No. 10, effective January 1964, of the Reader's Digest. Also, in a personal interview, we learned that they provide for geographically split advertisements that appear in that portion of the United States or a foreign country where the advertisers have a market. A west coast supplier with no distribution points in the East does not have to buy advertisements at national rates. The same is true of a U.S. company—not doing an export business—does not have to pay for advertising in the Reader's Digest distributed abroad. The advertiser pays for the advertisements in the zones in which he can sell and service his product.

Thus, regions 9 and 2 (covering New York and surrounding territories) excluded from the Reader's Digest advertisements would not prohibit unauthorized insurance companies from advertising in the other States if this bill becomes law. As an alternative, such companies could modify only their copy for advertising in regions 9 and 2 and, in so doing, comply with the provisions of this bill. We have been informed that selective advertising is common to the advertising mediums.

THE BROADER ASPECTS OF THE BILL

With the spread and growth of all forms of advertising media, it places State insurance regulatory laws in jeopardy if they cannot be enforced.

Under the present law, it is accepted as unlawful for an agent to explain a policy or any desirable features of a company not authorized to transact business in this State. It is predicated on the belief that New York law is formulated by the legislature or the Governor for the purpose of protecting New York citizens. Minimum standards of financial responsibility, expense limits, rates commensurate with benefits, and other policy provisions were established for the best interest of New Yorkers.

Why should our taxpayers support a multimillion dollar annual insurance department budget if their work can be circumvented by a "person" on a television screen in a living room, enticing our citizens to telephone a local number where an (unlicensed) clerk gives answers to questions, completes over the telephone an insurance application giving details of birth date, address, beneficiary, and condition of health; and, then, the unauthorized policy is written and legally delivered by mail from outside the State borders. No signatures are required.

Let us quote a recent experience on the telephone:

New York citizen: "I called this number to get some information on the life insurance policy I heard your radio station advertise last night.

This is the telephone number given on the air, is it not?"

Employee of radio station: "Yes."

Citizen: "Is this insurance company licensed to sell policies in the New York State?"

Employee: "Oh, I believe so. We would not advertise a company unless it was legal to do so."

To write into State law standard policy provisions—but not be able to enforce them merely because the policy is solicited by radio, television, or newsprint advertising—raises the question of effectiveness of insurance laws or the need for the New York Insurance Department.

The New York State Association of Life Underwriters—whose delegates have been concerned over this problem for many years and have complaints on file with the insurance department as far back as 1961—supports this bill both on the basis it is needed and its provisions have merit.

As 5,600 career life insurance agents who are active in daily contact with people in every county of the State, we are more concerned with the protection of our policyowners than the freedom of 1,450 life insurance companies not admitted to do business here to be able to advertise without restriction in New York State. Our encouragement to the legislature to pass this bill has been recognized by unsolicited letters as far south as Alabama by an associate general counsel of an unauthorized company whose letter we attach. Favorable publicity is being given in California and Michigan of their efforts to curb the abuse of State insurance laws through selling by unauthorized companies.

We support this bill and ask the Governor to sign it.

NEW YORK STATE ASSOCIATION OF LIFE UNDERWRITERS,
By SPENCER L. MCCARTY, C.L.U.,
Managing Director.

[From National Underwriter, Apr. 4, 1964]

NEW YORK BILL CURBING ADS OF UNLICENSED INSURERS PASSES

ROCKEFELLER PRESSED BY DEPARTMENT TO APPROVE, BY ADVERTISERS TO VETO

(By Robert B. Mitchell)

The Condon-Russo bill aimed at hindering unauthorized insurers from advertising for applications from New York State residents has been passed by the New York legislature and is awaiting action by Governor Rockefeller.

If the Governor does not approve the bill before midnight April 25 it automatically dies, but by longstanding tradition no bill is allowed to die by default. The Governor either approves or vetoes.

CONTROVERSIAL BILL

The bill is highly controversial. It is supported strongly by the New York department and the New York State Association of Life Underwriters and is opposed with equal vigor by Life Insurance Association of America, by some of the nonadmitted insurers individually, by insurance publications, particularly those published within the State, and by newspapers and magazines of general circulation.

In addition to objections from unauthorized insurers actually seeking business from residents of New York, the bulk of the protests against the bill comes from those who contend it would unintentionally harm insurers having no intention to solicit business from New Yorkers and hence would cut into advertising revenues of publications, both insurance and general.

The bill adds to the section of the present law pertaining to "acting for or otherwise aiding unlicensed or unauthorized insurers" the following language: "No person, firm, association, or corporation shall in this State publish, broadcast or televise through any newspaper, magazine, periodical, radio station, television station, or other media of public communication any advertisement, public announcement or other notice which directly or indirectly sets forth the advantages of or solicits business for any insurer not licensed or authorized to do business in this State.

"No person, firm, or corporation shall sell or distribute in this State any newspapers, magazine, periodical or other written media printed outside of this State which contains any advertisement, public announcement, or other notice which directly or indirectly sets forth the advantages of, or solicits business for, any insurer not licensed or authorized to do business in this State unless such advertisement or other notice shall state conspicuously thereon in boldface type not smaller than 10 point: 'Not licensed or authorized to do business in the State of New York.'" (National Underwriter text type is 8 point.)

One of the main objections made to the bill is that a nationally distributed magazine published in New York State would be barred from accepting advertising from any insurer not licensed in New York State. Nationally distributed magazines published outside the State and distributed within the State by any

other means than mail could carry advertising of nonadmitted insurers only if it bore the 10-point warning required by the bill. A more costly alternative, of course, would be to print special editions for newsstand sale in New York State, in which advertising of nonadmitted insurers would be omitted or would carry the 10-point warning, thereby permitting mailed copies and those circulating in the rest of the country to carry the advertising free of any caveat.

Publishers of the insurance journals have been assured by the New York department that the department would not enforce the measure against them if it should be signed by the Governor, since insurance journals do not circulate among the general public and do not carry advertising inviting readers to apply for insurance by mail. The department has also indicated it would be willing to support an amendment at the 1965 legislative session to specifically exempt insurance publications. However, most of the publications affected would prefer to see the pending bill vetoed, and wait until next year for a bill that will be free from unintended effects.

McCarty Hopeful on Bill To Curb Ads of Unlicensed Insurers

The outlook is good for the passage of the New York bill that would prohibit publications and radio and TV stations in the State from carrying advertising of unlicensed insurers and would forbid the sale or distribution of out-of-State magazines carrying such advertising unless it stated conspicuously that the insurer was not licensed in the State.

This view was expressed by Spencer L. McCarty, Provident Mutual, Albany, who is managing director of New York State Association of Life Underwriters, at a meeting of Fulton-Montgomery Life Underwriters Association, held in Gloversville, N.Y.

Mr. McCarty said he felt Governor Rockefeller will sign the bill if it passes. It now is before the insurance committees of the senate and assembly.

The warning in advertisements carried in out-of-State magazines would have to be in boldface type not less than 10 point in size. (This item is printed in 8-point type.) It would have to state, "Not licensed or authorized to do business in the State of New York."

Unlicensed insurers have been stepping up their activities in recent months. Mr. McCarty told of a radio station in the Troy-Schenectady area. A local phone number was given in the commercial. When Mr. McCarty called up, he was given the number of a New York City advertising agency. When he called the agency, he was told that if he bought a policy it would be sent direct from the company's home office in Texas. The agency contended it was not doing business in New York, even though it had a telephone number in the State.

Mr. McCarty said the New York State Tax Department, which has some 2,000 employees, had requested rosters of State association members in the Albany-Troy-Schenectady area so that department personnel would know who to consult about life insurance. More recently, the department requested a similar roster for the benefit of its personnel in the Buffalo area. Mr. McCarty called this development an encouraging sign. He pointed out that the increasing complexity of the insurance business is forcing people to ask questions.

Mr. McCarty mentioned the NALU professional and association liability policy as an additional indication that agents are being held responsible for their actions. He said the place of the agent will be different in the future. He urged his listeners to be sure they were ready to fulfill the promise of the Institute of Life Insurance advertising, which is based on the theme that people should "See your agent, he's trained to help you."

As an example of the new recognition that the agent is getting, Mr. McCarty told of a trust company whose trust officers routinely ask clients, "For our records, who is your life insurance man?" If the client has no agent, he is given a copy of the local association roster.

Mr. McCarty stressed the need for better communication between home offices and the field, though encouraging progress is already being made. He predicted that better two-way communication would go far toward solving the problem of top executives of companies hearing only what their junior executives think they'll be pleased to hear.

(Text continued from p. 118.)

Mr. Colburn. In New York they have attempted to stop the activities of the unauthorized insurance carrier. They were unable to. I

think this is very important, because this is the very meat of the problem.

> To write into State law standard policy provisions—but not be able to enforce them merely because the policy is solicited by radio, television, or newsprint advertising—raises the question of effectiveness of insurance laws or the need for the New York Insurance Department. * * * Favorable publicity is being given in California and Michigan of their efforts to curb the abuse of State insurance laws through selling by unauthorized companies.

Now this bill was passed and would have been a tremendous weapon in the State regulation efforts to do something about the evils of unlicensed and unauthorized insurers and the direct mail business. It passed. It was sent to Governor Rockefeller. He had to take action by April 25. The National Underwriter says that the bill is "highly controversial."

It further says:

> It is supported strongly by the New York department and New York State Association of Life Underwriters and is opposed with equal vigor by Life Insurance Association of America, by some of the nonadmitted insurers individually, by insurance publications, particularly those published within the State, and by newspapers and magazines of general circulation.

It is my understanding that the bill died on the Governor's desk.

I think that most insurance commissioners, in candid comment, would agree that certain and limited Federal assistance could be of invaluable help in providing the tools with which State insurance department could do a more effective job in the control of the deceptive insurer.

I say this with some sense of desperation inasmuch as we in Michigan attempted repeatedly with all of the resources available to us, including the full efforts and cooperation of the State's attorney general, Frank J. Kelley, and his consumers protection division, to control these abuses. While some progress was made, it is nowhere near what is necessary.

Since there exist policies, procedures, and laws within the various States that adversely affect the very welfare of all citizens. I believe we have reached that critical moment when the U.S. Senate must inspire the many State authorities into prompt and proper action.

If the necessary action is not taken by the individual States, or if it becomes apparent that State regulation cannot satisfactorily cope with the problem of interstate insurance business, then I for one would foster the needed Federal authority to more adequately protect the general welfare and best interests of all our citizens.

Thank you very much, sir.

Chairman WILLIAMS. Thank you very much.

You have come with a background of obviously very comprehensive experience and this statement is most helpful.

These mail-order outfits, those who are the least responsible and the predatory types that we have been discussing all day, operate from their home base, wherever it is, out across the land, and do not come under the purview of State law because they are not residents in any sense, in the States where they operate, outside of their home base; is that right?

Mr. COLBURN. In most instances, that is correct, sir.

Chairman WILLIAMS. These are the ones that are in commerce, so they are subject to Federal purview; is that right?

Mr. COLBURN. I believe so, sir.

Chairman WILLIAMS. The Federal Trade Commission has indicated that it accepts its responsibility to analyze their selling practices and their representations and feel that they have a good staff to analyze these practices and bring suit on the basis of cease and desist with injunctive powers and finally contempt action.

Just to state the procedure takes some time, but with all the investigations and then bringing the action and processing it through the courts does take considerable time. In fact, I am advised that it is not inordinate to take a year for final consideration and all the while the predator is at his immoral business. So the relief seems quite inadequate. Do you agree?

Mr. COLBURN. Very much so.

I believe that the guidelines that are to be adopted formally by the FTC are the same guidelines that have been practiced and are only now being formalized into black and white.

Chairman WILLIAMS. But even with the guidelines they will be charlatans if they are going to be charlatans; we know they are in the minority, but it is a very important minority in terms of hardship. Even with the formalized guide, the machinery of correction of abuse is very slow, is it not?

Mr. COLBURN. Very much, sir.

I think the FTC is terribly handicapped in what it can and cannot do. I think they do an outstanding job with what they have to work with and I think they, themselves, will admit that their hands, to a great degree, are tied. Of course, I am used to NAIC resolutions, whether they be joint resolutions with the FTC, or joint resolutions with the industry, or joint resolutions with you name who, because I know that these joint resolutions have not accomplished much over a period of time.

I am rather fascinated by the attitude of the National Association of Insurance Commissioners. I happened to bring with me what I think to be a rather splendid report by the National Association of Insurance Commissioners. This was a subcommittee that was set up in 1958 to study and review laws necessary and essential to perfect the system of regulation of the business of insurance by the several States as contemplated by the McCarran Act and by current needs, in the public interest.

I'm certain that the NAIC is interested and sincere about their attempts to preserve State regulation. It seems to motivate almost every move they make. And in reading Commissioner Morris' report, which was read by Commissioner Nelson, for whom I have a great deal of respect, I can't help but think of this. I respectfully turn to page 24. Now remember this goes back to 1958. The NAIC itself says that the problems arising from the activities of unauthorized insurers have occupied the attention of various committees of the NAIC from 1888 to date.

They talk about control of advertising. They mention the FTC. But then they say:

It is in this field we find the first step toward Federal regulation.

So I wonder if at times the NAIC is not more interested in possible Federal intrusion than they are in properly protecting the best interests and general welfare of all of the citizens of this country in the area of insurance regulation.

They go on to say that most States have taken action. They talk about the uniform unfair trade practices act, and they say that all States should adopt the NAIC advertising rules. In view of the Federal interest in this area it is recommended that the States reexamine their laws.

Chairman WILLIAMS. Now as far as the NAIC is concerned, I would imagine that its membership does not include the worst of the predators here in the sale of health services or health insurance, is that right?

Mr. COLBURN. Well, the NAIC, sir, is nothing more than just a loosely knit organization of all the insurance commissioners of the 50 States, the District of Columbia, and Puerto Rico. As a matter of fact, I understand that the Superintendent from the District of Columbia some time ago gave up going to NAIC meetings because of their many inactions. Of course, this is only hearsay. I might add, however, that it is not unusual for a commissioner to become disenchanted with the ways of the NAIC.

Chairman WILLIAMS. Even with the best of intentions, if it were a good group of people with the most worthwhile goals and objectives——

Mr. COLBURN. They have no powers.

Chairman WILLIAMS. That is right.

Mr. COLBURN. They meet twice a year. There are some 50 commissioners and industry sends 1,500 to 2,000 men to see that they not do anything and generally they do not.

Chairman WILLIAMS. Let's hope the industry does not pay for the convention.

Mr. COLBURN. They also pay for the convention in the sense that they register and pay fees before the convention.

The various States will supply budgets to their insurance departments for members of the department to attend. Frankly, I have never seen too many NAIC members purchase their own breakfast, dinner, or luncheon. I think that this is fine. I do not think that there is anything wrong with it, I think it is camaraderie at its best, and I plead guilty to a few of those social gatherings myself.

Chairman WILLIAMS. How about the transportation?

Mr. COLBURN. No; I think this is all taken care of by the State. In fact, I am quite certain it is. There are no shenanigans in that respect, but, of course, as long as you keep a man eating, laughing, and drinking, the fewer moments he has left to take care of the business he is there for and this, I believe, is why the NAIC studies and restudies, studies and restudies, and restudies and restudies and so on.

Chairman WILLIAMS. Around here in accepting a gratuity, the test for some is that it is all right to take the gratuity if it can be consumed at one sitting.

Mr. COLBURN. I think this meets that test, sir.

I think, however, that they hold the indoor record for the longest sittings, but they certainly do meet your test.

I think that *Travelers Health Association* v. *Virginia*, which was discussed earlier, even within that case, remains the matter of enforcibility of penalty judgments or injunction orders in the unauthorized insurers' domiciliary State. This is a big problem. This was pointed out in 1958. They recommend in view of this case, that since the problem of enforcement is still unsolved that the committee study the advisability of drafting a model bill providing for enforcement of penalty judgment and injunction orders in the State of an insurance domicile, et cetera. I do not know how many of these have been done. They talk about the NAIC Uniform Unfair Trade Practices Act that provided that no person shall engage in unfair practices. The fascinating thing in this report, I think, is table O. This report is available and I was quite surprised that the NAIC executive committee did not refer to it, although I think I have good reason to believe why they did not. Table O sets forth the control over unauthorized insurers through legislation in the various States.

There are several major areas. Do the States have a definition of doing business? What is doing business? Are you doing business if you consummate something through the mails in this State or are you not doing business? The tables show that 32 States do not have a definition of doing business, 20 States do. We hear much about initiation of service of process. In 45 States the insured or the beneficiary has the right to initiate the service of process, and 7 do not.

Now we talk about the insurance commissioners. We know that the insured can go and initiate a service of process. It can take time. We have these very small claims of $50, $100, $150, $200 that might not be worth while hiring an attorney for.

What powers do the insurance commissioners have? Well, in 48 States the insurance commissioners have no power for the initiation of service of process. In 48 States there is no process, no injunction power for the commissioner. In 16 States, there is no power of penalty. Now this was in 1958. I would like to see the NAIC bring these figures up to date. What have they done in the past 6 years? Maybe all the States have not set forth what was recommended in 1958. If they have, then we do not have a problem. But the most glaring problem, and I think the one that could very easily do away with the problem of direct mail by unlicensed and unauthorized insurers, is the requirement of the State in which a company is domiciled.

For example, in Michigan, a company that is domiciled in Michigan by law, cannot solicit business in States in which they are not licensed. Now if every single State, plus the District of Columbia—and I noticed two unauthorized ads in this morning's Washington Post—I called the department to check on it—and Puerto Rico were to adopt within

their regulatory act the law that a domiciled company cannot do business in a State where they are not licensed, you would not need any hearings. You would not have the direct mail problem. Unfortunately, as of 1958, only 17 States had this law.

Chairman WILLIAMS. You said domiciled now?

Mr. COLBURN. If every company, in every State, were bound by a State law that said that domiciled companies could not conduct business in States in which they are not licensed you would not have unlicensed and unauthorized insurers.

Again, it seems to me, and maybe I'm simplifying it, the problem can be averted simply by making the other 35 States and the District and Puerto Rico adopt this legislation.

Chairman WILLIAMS. We are progressing at tortoise speed toward that objective, as I interpret your objective.

Mr. COLBURN. I'm not even certain of that pace. I am not sure what actual progress has been made since 1958.

Chairman WILLIAMS. Mr. Colburn, the testimony here today clearly shows that the problems of controlling the abuses of fly-by-night unlicensed insurance companies are many and pressing. In considering this problem I have developed—in broad outlines, at least—a tentative proposal which might be effective.

What would your opinion be of a measure which would authorize State insurance commissioners, or any appropriate State official, to utilize the Federal court system to protect their citizens from the abuses of unlicensed insurance companies?

Suppose, for example, that insurance companies, as a condition of doing business in States where they were not licensed, were required to post a bond based upon the amount of business the company had in States where it was not licensed, and that this bond would be subject to any final judgment upon an insurance contract. Suppose further, that unlicensed insurers were required to file a report with an appropriate Federal agency indicating the company's liability in States where it is not licensed to do business, and that this information would be turned over to the State licensing authority.

In this context, if a citizen of a State had a claim against an unlicensed insurance company, or if the State insurance commissioner wanted to require an unlicensed insurance company soliciting business in his State to post a bond and file a report, the individual or the State commissioner could bring an action in the Federal district court.

Under this proposal, the Federal Government would not initiate the action or control the insurance companies—this bill would only assist the State to protect its citizens from abuses of unlicensed insurance companies by providing an effective legal remedy and forum.

What do you think of that idea?

Mr. COLBURN. I think that it would be a progressive and forward-moving step, most certainly. I think that mail-order insurance, itself, constitutes a transgression of the basic principle of the insurance industry. That, simply being a good faith effort to abide by State regulation. Any action that can be taken by the Federal Government to inspire action by the States, I think, would be most welcome and most needed. I heartily approve of this as a starting point.

Chairman WILLIAMS. The commissioners, State by State, are powerless before the abuses of the full mail-order outfits that we are talking about; is that right?

Mr. COLBURN. I think the figures in appendix O of the 1958 laws and regulations by the NAIC subcommittee, stated that only 4 of them had power, so that would be 48 who are powerless.

Chairman WILLIAMS. And the aggrieved individual cannot find the mail-order company to nail them with a summons.

Mr. COLBURN. In most instances, Senator, these people are in this market because they have not been able to afford the coverage set forth by the reliable commercial carrier. These people, therefore, are usually unable to afford the necessary attorney fees that it takes to pursue the unlicensed carrier.

Chairman WILLIAMS. But even if they had money to bring a suit, and it is not prohibitively costly to start an action——

Mr. COLBURN. I am not suggesting that it might be. However, I think it a shame and a pity that people in the individual States pay millions and millions of dollars a year for taxes, portions of which supposedly go toward protecting them in insurance matters and then find that the State cannot offer them this protection.

I hate to see anybody have to pay anything over and above what they are paying for through good government.

Chairman WILLIAMS. I agree. But beyond that, the mail-order house is present in the State to be sued.

Mr. COLBURN. That is correct.

Chairman WILLIAMS. So this proposal has been made, which you seem to approve of, would make a mail-order organization a resident for purposes of being sued by the commissioner or by the client.

Mr. COLBURN. In many instances, the insured or the beneficiary of that insured have that right, service of process. However, it is the insurance commissioner who has no powers, and I think this is where the meat of that bill would come into play.

Chairman WILLIAMS. We have gotten a great deal out of this and we could continue, surely, and improve our time further, but the clock is running rapidly against further discussion at this point.

We are very, very grateful to you, Commissioner.

Mr. COLBURN. Thank you very much.

Chairman WILLIAMS. Next, we have on our list Mr. Loren A. Hicks of Pompano Beach, Fla. We certainly appreciate your presence here and recognize that you have come a long distance to be helpful to us, Mr. Hicks.

STATEMENT OF LOREN A. HICKS, PRESIDENT, NORTH BROWARD SENIOR CITIZENS CLUB, INC., AND TREASURER, FLORIDA STATE COUNCIL FOR SENIOR CITIZENS, OF POMPANO BEACH, FLA.

Mr. HICKS. Thank you.

Mr. Chairman and members of the committee, my name is Loren Hicks. I am the founder and president of the North Broward Senior Citizens Club, Inc., of Pompano Beach, Fla. There are two inaccu-

racies in my statement. One I made myself. It was in the confusion of taking my wife to the hospital. In the next sentence I state, "This club, with 300 members"—300 members was more likely when we organized the first day. It is now in excess of 700.

On page 2, in the next to the last paragraph, that should read $100 per day in 1970 instead of $70 per day.

I will comment briefly on my written testimony because, as I understand, your time is limited here. I will state that before the State of Florida set up the insurance advisers in the State, I have consistently advised the members of my club to stay clear of the fly-by-night insurers with little capital who are liable to raise their rates much faster or quicker than the large giants of the industry.

In the third paragraph, I state that private insurance has had over half a century to do the job and has failed to solve the problem. That is true. Private insurance takes in the salesman's commissions, the supervisors' salaries, the regional offices, the home offices, and, last but not least, profit.

This entails a great expense. For instance, referring down to the bottom of this page, the Beneficial Life Insurance Co. sent two salesmen 50 miles from Miami up to Boca Raton to sell this insurance. There must be an awful lot of profit in this procedure to sell. It costs $500 to $600 for a retired aged couple to get comprehensive policies that will pay possibly 80 percent of their benefits which has been described as Cadillac policies by someone previously. The 50 percent of us who need insurance of this type the most, cannot afford it. It would take about one-third of their average income. In my own case, my income from pension and social security is less than $170 a month. I cannot afford that. The policy that I have is a company-matched policy. It helps quite a bit, but it pays only $10 a day on hospital room and board. Again, I will have to take from my life's savings for my wife's residence in the Pompano Beach Hospital.

Now this policy, you may have it. The man does not want it anymore.

Chairman WILLIAMS. Let us pause there. Are you submitting that policy for us?

Mr. HICKS. Yes, you can have it. He does not want it anymore.

Chairman WILLIAMS. Well, it will be a useful documentation for our files if we can have it.

Mr. HICKS. Yes. According to the telephone conversation with him, this man that wrote up the insurance told him that only 5 years' previous existing conditions would be considered. It seems as though he was more interested in getting a signature on this policy than explaining to the man what it was all about. That was also the same complaint from Mr. Albert Ross of Lighthouse Point, Fla. He told me that personally it was the same insurance company.

Chairman WILLIAMS. That is a Florida company?

Mr. HICKS. Yes, they are licensed to do business there. But, as Mr. Colburn just before me mentioned, it looks like huckstering. Here is another operation that happened in Broward County. A Mr. Henry Mathes was selling Boward 65 policies. I do not know how he was ever able to sell them.

Chairman WILLIAMS. They were playing on an accepted reputable name.

Mr. HICKS. Yes. The Great Atlantic Life Insurance Co. was the underwriter.

Chairman WILLIAMS. I mean by bringing in the 65, Broward 65. Now you know there is the Connecticut 65 program, the Massachusetts 65 program.

Mr. HICKS. Well, he is playing on the name.

Chairman WILLIAMS. That is the point.

Mr. HICKS. This man could never be licensed in the State of Florida and I do not see how Great Atlantic ever permitted him to operate. They were underwriting Broward 65. How did this happen? He is now under indictment by the grand jury for malfeasance of operation.

Here is a newspaper ad. This is not fraudulent, but I think this is a takeoff on the Traveler's Insurance, implying complete coverage You know, they have that on radio and television. What can you buy for 5 cents? It is more or less misleading. (See p. 136.)

Chairman WILLIAMS. We would like to include that in the record too, at this point. It is 50 cents a day?

Mr. HICKS. It is 50 cents a month. If it hurts, it is covered. You send in your claim and they will send you a band aid.

There was another ad. I called them up. I told them I am 73, my wife is 68, how much is it?

The answer was $224 a year. I cannot afford that, not for a $10-a-day hospital insurance policy. There is nothing misleading, but you know us poor devils, we are laymen and we cannot analyze these policies. Here is one here, 2 years ago, in 1962, low cost, medical plan unveiled. It did not last very long. That was Blue Cross, $73.20 a year for a couple. Well, they lost money on it. They lost money on it and here is an item on Blue Cross in the Wall Street Journal of July 19, last year. Blue Cross insists that insuring everyone over 65 is a losing business and it must be subsidized somehow. I will tell you how it is being subsidized. It is being subsidized by sons and daughters under the age of 65 by paying higher premiums for insurance. Those premiums are costing more than $13 a year, which is the schedule of hospital insurance under social security.

In Florida they have had three increases by Blue Cross in the last 4 years. Michigan Blue Cross lost $18 million during 1962. They are now asking for a substantial increase in premiums from all subscribers. In other words, all subscribers are subsidizing the over-65 policies.

The New York plan went up in smoke. New York Blue Cross had to dip into its reserves and the reserves are premiums from all policies. Again, people under 65 are helping to pay for the health care insurance of people over 65. In New Jersey Blue Cross will raise its rates 18½ percent.

Chairman WILLIAMS. That was only half of what they asked, you know. They asked 32 percent and got 18 and said that they would be back for a raise within a year.

Mr. HICKS. The Continental said, I remember, they were making 1 percent profit on over-65 policies. Then they looked in their books and they found out, they say, they are breaking even. I am enough of an accountant to juggle the figures to show that they are losing money, or I could make it run the other way. Over 30 percent of over-

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PREMIUM RATES CANNOT BE CHANGED—UNLESS THEY ARE CHANGED FOR ALL HOLDERS OF POLICIES OF THIS FORM.

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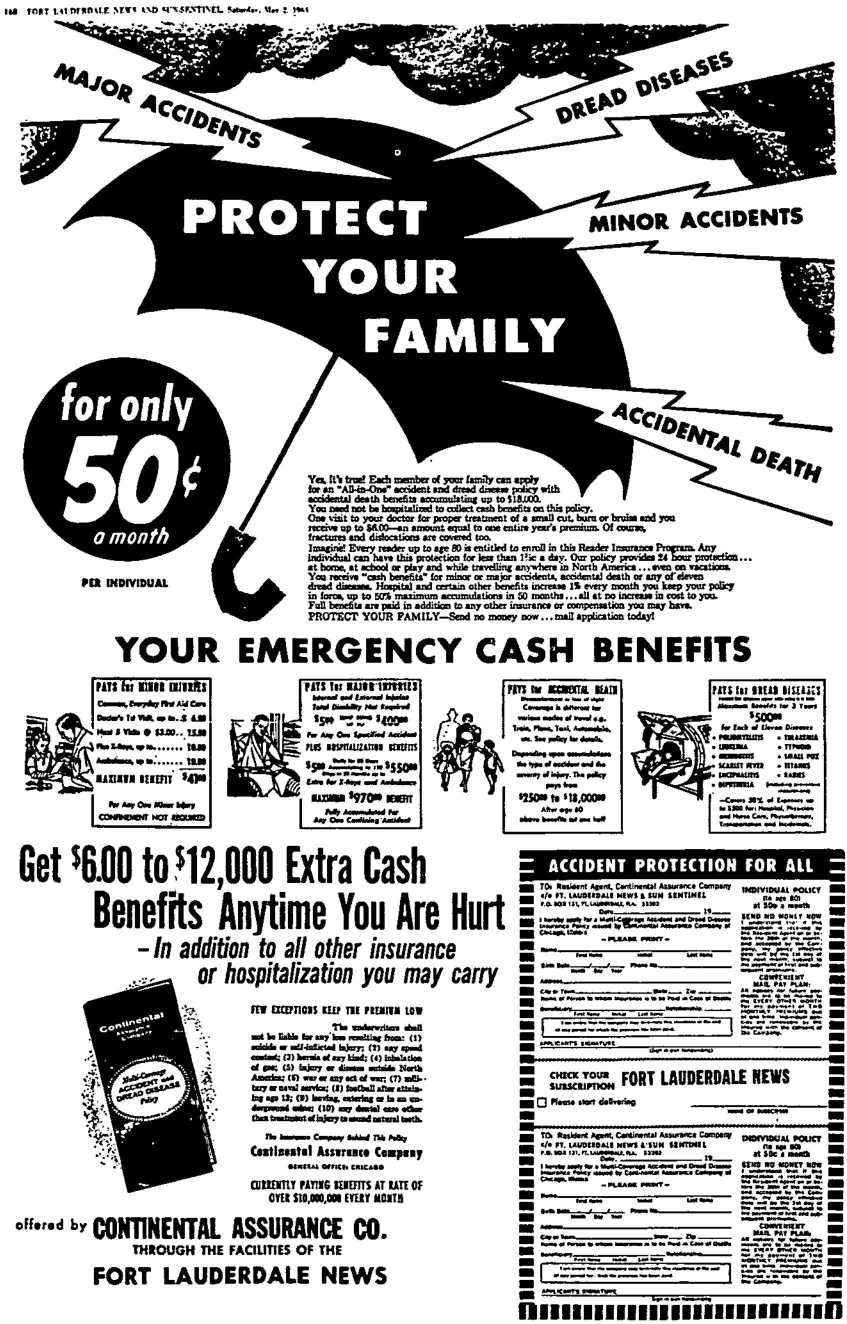

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Fully Accumulated For Any One Continuing Accident
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Coverage is different for various modes of travel e.g. Train, Plane, Taxi, Automobile, etc. See policy for details.
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After age 60 above benefits at one half
PAYS for DREAD DISEASES
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THROUGH THE FACILITIES OF THE
FORT LAUDERDALE NEWS
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INDIVIDUAL POLICY
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CHECK YOUR SUBSCRIPTION
FORT LAUDERDALE NEWS
Please start delivering
TO: Resident Agent, Continental Assurance Company
c/o FT. LAUDERDALE NEWS & SUN SENTINEL
INDIVIDUAL POLICY
SEND NO MONEY NOW
CONVENIENT MAIL PAY PLAN:
APPLICANT'S SIGNATURE

65 policies are being paid by children and 15 percent of the cost of senior citizens' benefits are paid by insurance.

I have a friend in Fort Lauderdale. I think he is worth at least a quarter of a million dollars. He has three of those Cadillac policies. Every time he goes to the hospital he makes money. That is what is driving insurance rates up. Not only that, but your doctors are putting people in the hospitals that do not need to be there. They could be treated at home or in the doctor's office.

And there is all of this unnecessary operating.

Chairman WILLIAMS. Does your club support the medicare program?

Mr. HICKS. Absolutely.

Chairman WILLIAMS. That is one of the features that makes it most appealing to many of us, it would permit doctors to treat the non-hospital case under the program of home care reserving the hospital space for those who are true hospital cases.

I do not know why this does not come through to more people.

Mr. HICKS. That is not the solution for the entire problem. We just want a few crumbs from the table.

Chairman WILLIAMS. Could I ask you a question now? You do not have to be precise. I am sure you could not be precise. You are the president of a group of 700 members of your senior citizens group.

Mr. HICKS. 700-plus.

Chairman WILLIAMS. Just in round numbers, what do you suspect is the average annual income of your average member?

Mr. HICKS. The latecomers are getting more social security than those of us 8 years ago when I left. You see, my social security then was based on $3,600 a year, although I was making more. And my company pension is very small, around $23 and something a month. But those coming in lately are getting more. I would say that their average income from all sources would be around $2,500 up to possibly $3,000 in some cases. In our advanced ages with doctors' care, drugs, you would be surprised to know that I spend about $25 to $30 a month for drugs for my wife. I may get that way someday myself.

Chairman WILLIAMS. That would represent, of your annual income, of $2,500, just drugs alone, 10 percent.

Mr. HICKS. In my case?

Chairman WILLIAMS. Yes.

Mr. HICKS. Well, $170 a month in income is less than $2,400 a year. I cannot afford a $500 to $600 policy for myself and wife. Most of our people that belong to this club cannot afford it either.

Chairman WILLIAMS. Judging from harsh economic facts about drugs, I think we see part of the reason why people, particularly in retirement, reach for these promising plans that you see in the ads which you have exhibited.

Mr. HICKS. Please understand that we are not against Kerr-Mills. We are not against good insurance. We need both. We need Kerr-Mills, when we become ruined financially by heavy hospital bills. Kerr-Mills is fine. We wish they had that in Florida the same as they have it in the State of New York. They have a wonderful program.

Chairman WILLIAMS. You are from Broward County. Your senior citizens group is countrywide, is it not?

Mr. HICKS. Well, I have organized five clubs in the county.

Chairman WILLIAMS. There must be, literally, in the State of Florida, thousands and thousands of people situated in much the same condition and situation that you are here describing.

Mr. HICKS. That is very true, yes.

If Kerr-Mills was expanded in Florida the same as it is in New York, I would be very thankful. You see, we have one-third the number of retirees as the State of New York.

We have had the pitiful appropriation of $3 million for 2 years, and the State of New York has had an appropriation of $93 million for 1 year. As a matter of equity, we should have even more than one-third of the amount that New York has got, because our people are down there for reasons of health and a great number of the over-65 in New York, quite a few of them, are still working.

Actually, by contribution to the National Treasury, we are subsidizing the State of New York for Kerr-Mills.

Chairman WILLIAMS. Well, I imagine there should be strong congressional support for King-Anderson, from Florida.

Mr. HICKS. Our people lack the education on the King-Anderson bill, frankly. The press almost 100 percent is against it. The talk of why should people that are wealthy be under this program for the same reason that my friend down at Fort Lauderdale, who is worth, as I said, at least a quarter of a million, is drawing social security. It is because he paid into it. He has earned that premium. And the same way under this hospital bill, if you paid into it, you are entitled to it no matter how much you are worth. We need something.

Chairman WILLIAMS. Of course, that is not the subject matter today.

Mr. HICKS. No.

Chairman WILLIAMS. But it is ancillary to it. The failure of that program, the high cost of adequate care to lower incomes in retirement—all of these things give us the reasons why people are less than cautious about purchasing these plans that are at best ineffective in meeting the needs and at worst, downright frauds. Do you have anything further, Mr. Hicks?

I just want to say that you personified very dramatically just what we have been talking about here in the health programs that miss the mark of honesty in some cases and miss the mark of need in other cases.

Mr. HICKS. I do not want to miss the letter that was given to me from the State of Texas, from the Constitution Life Insurance Co. I am frank to say that this policy would confuse me.

"The maximum benefit of 15 days at $15 a month" looks like you would get $15 a day. But it is not. It is $15 a month, and this poor woman only got $7.50 for the month.

Chairman WILLIAMS. Are you going to submit that statement, the letter as part of your statement?

Mr. HICKS. Yes.

Chairman WILLIAMS. I notice in this letter to Mrs. Hebbeln, this line appears:

From our total payment it was necessary to take off 50 percent due to your age.

Mr. HICKS. She did not know about that, I will bet a dollar, when she took the policy out. This is a real honey.

Chairman WILLIAMS. Here is the last line. You read it.

Mr. HICKS (reading):

How are you feeling now? Better, I hope. We wish you the best of health. Your friends at Constitution Life.

Chairman WILLIAMS. That comes right after:

From the information we have, it does not appear that your policy would pay more benefits.

Mr. HICKS. You know, last month, in a period of 3 weeks, I had three insurance people try to infiltrate our club. They are just a couple of jumps ahead of the vitamin peddlers. We have had them, too.

And in my statement, I have stated, and it is true, that I have been offered $200 for the mailing list of my club. The way I get rid of these boys, I say, "Well, send me in a sample policy. I am kind of an expert on this. I want to look it over." I never get it.

MR. HICKS BEFORE THE SUBCOMMITTEE

Chairman WILLIAMS. And you could say to the pill pushers, or the vitamin fellows, "Let me try a bottle."

Are any of your folks taken in by some of the fraudulent claims of cures for arthritis or other crippling serious diseases?

Mr. HICKS. Not that I know of, no. Our big effort is the way the vitamins and some kinds of health foods, et cetera, come in. I tell the people, "Well, if your diet is correct, you will not need these vitamin pills and health foods."

Chairman WILLIAMS. That is what the doctors here in this field told us here about a month ago, particularly the doctor from Harvard.

I will tell you, Mr. Hicks, we will long remember your appearance here with the deepest gratitude. Thank you.

(The statement of Mr. Hicks follows:)

(Text continues on p. 144.)

THE NORTH BROWARD SENIOR CITIZENS CLUB, POMPANO BEACH, FLA.

Mr. Chairman and members of the committee, my name is Loren Hicks. I am the founder and president of the North Broward Senior Citizens Club, Inc., of Pompano Beach, Fla. This club, with 700 members, is dedicated to the welfare, not only of our own people, but of all senior citizens throughout the Nation.

The constitution of our club states we favor health care and hospitalization for the aged through social security. We are an independent group affiliated with the National Council of Senior Citizens. We are convinced that this is the only form of protection that will solve the problem of financing health care through social security.

At our founding meeting 3 years ago, I was approached by an insurance agent. He wanted to gain exclusive rights to sell insurance through the club for the purpose of enriching himself. It has been my policy to repeatedly advise our members to deal only with the giants of the industry and to beware of the smaller companies, many of whose policies are not worth the paper they are written on. Now, even many of the policies issued by the giant companies offer little protection because of increased costs.

Private insurance has had over a half century to do the job and has failed to solve the problem. The only available insurance to give decent protection is priced out of reach of most senior citizens. The cost of these policies involves an outlay of from $500 to $600 for a retired aged couple. This sum constitutes about one-thirds of their average income. I consider myself to be a little better off than the average retiree. My income from social security, plus company pension, is less than $170 per month. I am lucky in that the health insurance I carry is a company-matched policy. But it pays only $10 per day for hospital room and board, plus very limited benefits. However, this is all I can afford due to the heavy medical and drug bills for my wife, who is now in the Pompano Beach Hospital.

Once again I shall have to draw from my life savings for this purpose as I did 2 years ago when I spent a week at Holy Cross Hospital. It is true that I have a modest amount of savings, but did I work and save only to use this money for doctor, hospital, and drug bills? It was saved in order that we might supplement our meager income, so that by careful management we might live in some semblance of decency.

We senior citizens are not only at the mercy of fly-by-night insurance companies, who advertise through the newspapers and by mail, but we are also being victimized by slick insurance salesmen whose verbal statements do not coincide with the fine print of their companies' policies. Are these companies in no way responsible when they discover that certain of their salesmen have been consistently guilty of misrepresentation?

I offer for your inspection the policy of Beneficial Standard Life Insurance Co. of Los Angeles, Calif., together with the complaint of possible high pressure sales representation by their agent.

The same kind of complaint, with the same company, comes from Mr. Albert Ross of 2916 NE. 24th Avenue, Lighthouse Point, Fla., on policy No. 1-802-506-852.

In both instances, the agent stated that only preexisting conditions of 5 years previous would be considered. Yet the company takes a lifetime record of exclusion.

Another operation in this county was the selling of Broward 65 policies by one Henry Mathes. The underwriter of this insurance was the Great Atlantic Life Insurance Co. of Miami, Fla. I ask, why was this man approved by Great Atlantic with no investigation whatever, since he could not obtain a license to do business in the State of Florida? He is now under indictment by the grand jury for alleged malfeasance of operation. This person is one of scores who have personally visited me in an endeavor to infiltrate my senior citizen club. I have been offered the sum of $200 for the mailing list of our members by an insurance agent.

I am submitting for the record an ad that ran in our newspaper. The ad is legal and there could be no basis for a newspaper to turn it down, but

it is misleading and implies real protection from the financial problems of illness. You and I know that you can't buy comprehensive insurance for this kind of money.

I hope that something can be done about the small type which many of the policies are written in. This small type cannot be read by many retired people who have enough difficulty deciphering the technical jargon in most policies.

I would like to submit a letter which came to the Texas Council of Senior Citizens, forwarded by one of its members. There is little doubt that the policy was legally correct, but the woman was misled. This type of situation is what many of our members really worry about. They buy a policy but simply do not know what their real benefits are until they are ill.

The constant rise in hospital insurance can best be summed up by the statement of Dr. Norman A. Welch, president-elect of the American Medical Association, whereby he states in an article in the Los Angeles Times of November 14, 1963, that it is entirely possible that hospital costs will reach the sum of $100 per day in 1970.

To those of us who are subsisting on an income of $2,400 a year or less, what is the solution other than financial ruin when faced with a sizable hospital bill? I offer for testimony a recent clipping from the Miami Herald in which Dr. Lehman at the southeastern conference on health insurance stated that physicians are certifying nonexistent and unnecessary hospitalization that could be handled at home, or in the doctor's office.

The convenience of siphoning many patients into the hospital eliminates house calls by the doctor, produces quick revenue on a production-line basis similar to shooting fish in a barrel. The doctor on a quick visit asks, "How do we feel today, Mr. Hicks?" Ten bucks?

At many recent conventions of the AMA, doctors are cautioned against fee splitting and unnecessary operations. What good does this do? There is no control except on a local level and if discovered, the doctor packs his bag and moves to another area. Needless hysterectomies and unnecessary hospital admittances are driving insurance costs sky high. Neither insurance nor Kerr-Mills is the answer to our dilemma. Why in this glorious and wealthy country of ours is there no adequate provision for the hospital care for the aged? We are not even given the reward of wornout workhorses that are put out to pasture as an earned right for their past services.

BOCA RATON, FLA., *April 8, 1964.*

MR. LOREN HICKS,
President, North Broward Senior Citizens Club,
Pompano Beach, Fla.

DEAR MR. HICKS: Please find enclosed a copy of letter I have written to the American Association of Retired Persons, of Washington, D.C.

I think this insurance company should be brought to the attention of all retired or senior citizens in the State of Florida. I am also mailing a copy of this letter to the State insurance department at Tallahassee.

It appears that this company is out to get all the applications it can and immediately issue the policies so that they can get the premiums, and then if and when a claim is filed they start the investigations to find some cause for not paying the claims. This method enables them to get the premiums in hand, whereas if they made the investigations before issuing the policy and found some that were not acceptable and had to turn them down they would not get the premium, but by issuing the policy first and collecting the premium and leaving the investigation until a claim is filed, then they can deny liability.

I notice that you are having a lecture by Dr. Horber A. Kuvin to senior citizens on the subject of hospital insurance rackets, perhaps you can get this information to him before ths lecture.

I trust you wll make an effort to inform all members of your club regarding the risk they will be taking if they take a policy from this company.

Very truly yours,

URBAN Z. JOHNSON.

BOCA RATON, FLA., *April 8, 1964.*

Re insurance companies.

AMERICAN ASSOCIATION OF RETIRED PERSONS,
Washington, D.C.

GENTLEMEN: As a member of this association I have a matter which I think should be brought to the attention of all the association members.

During 1963 my wife and I decided that we needed some additional hospital insurance, as what we were carrying at that time did not give us complete coverage. We noticed an advertisement of the Beneficial Standard Life Insurance Co., of Los Angeles, Calif., which is a member of the beneficial insurance group. This company's office in Miami sent two high-pressure salesmen to our home. Since, as stated above, we were in need of additional insurance, we permitted these salesmen to take our application for a policy which they stated did not require an examination or statements other than two questions which they asked and was answered correctly. If there was any other questions on the application they answered them.

In 3 days the company issued this policy without making any investigation of Mrs. Johnson and myself. The policy was delivered by the same salesmen and they collected $379.12 premium. On December 30, 1963, Mrs. Johnson was taken sick and her doctor sent her to the hospital for 5 days as it was necessary to give her some liquids through the veins due to dehydration.

I filed claim with all three insurance companies; namely, Blue Cross and Mutual of Omaha and the Beneficial Life Insurance Co. Within 10 days the Blue Cross and Mutual of Omaha had paid this claim without question, but the Beneficial Life kept delaying stating that it was necessary for them to have more medical information, so they started to making investigations going back for 20 years into Mrs. Johnson's records. This I have no objection to, but it should have been done at the time they accepted my application and if the risk was one they did not want, then they should not have issued the policy. They still have not made any settlement of this small claim after 3½ months, but claim they are checking back into her record. Evidently what they are trying to do is to try and find something that they can claim was the result cause of this sickness. You can readily see that they are out to write these policies on senior citizens and then when they file a claim, the company starts digging back into their past records to find some excuse to deny the claim.

I am having my attorney to file suit for refund of my premium, but wanted to give you the information and name of the company so that you can save our thousands of members from the same fate we have had. I hope you can some way warn them, possibly through our magazine.

Sincerely,

URBAN Z. JOHNSON.

CONSTITUTION LIFE INSURANCE CO.
Chicago, Ill.

Re policy No. J–1,039,343.

Mrs. IRENE F. HEBBELN,
Houston, Tex.

DEAR MRS. HEBBELN: I'm glad you wrote. Any time there's anything about your insurance not fully clear be sure to write. I'm happy to answer your question.

Your sickness and accident policy doesn't cover doctor or hospital expenses. So I am returning the doctor bill.

Your claim was paid under part 5B, all other nonconfining sickness. The policy says we can pay a maximum benefit of 15 days at $15 a month. We paid benefits from December 15 to December 30. We also paid 50 percent accumulated benefits under part 8. From our total payment it was necessary to take off 50 percent due to your age. This is explained in general provision No. 1.

From the information we have, it does not appear that your policy would pay any more benefits. I'm sorry about this but I know you will agree we can only pay what the policy permits.

How are you feeling now? Better, I hope. We wish you the best of health.

Your friends at Constitution Life,

CHARLES MINER, *Claim Department.*

[From the Miami Herald]

HIGH COSTS ATTACKED BY DOCTOR

ATLANTA.—The spiraling cost of medical aid is caused by doctors, hospitals, patients, and insurance companies alike, a Hollywood physician said here Saturday.

Dr. David J. Lehman, Jr., an internal specialist, said in prepared remarks at the Southeastern Conference on Health Insurance that some physicians occasionally certify to "nonexistent disability or a need for treatment to conform to the coverage of insurance policies."

Often, he said, this is done because of pressures from the patient.

The reason for this pressure, he said, is to enable the patient to collect from his insurer on his illness. For this same reason, he said, patients are often hospitalized for operations or treatment that could be handled in the home or the doctor's office.

Dr. Lehman noted, however, that doctors' fees have increased by only 95 percent in the period from 1940 to 1960. During the same period, he said, hospital costs rose 344 percent.

He suggested the organization of speakers' bureaus throughout county medical societies to explain to experts and laymen what can be done to halt rising costs.

He suggested doctors should tell each patient why they should not be admitted to hospitals for minor operations or rest cures. He also said doctors should be able to explain the various kinds of health insurance that are available.

"A committee on health insurance," he said, "* * * will uncover evidences of 'overutilization.'" He said committees should also be formed in hospitals to prevent abuse of services.

Chairman WILLIAMS. We are quite honored to have Mr. Kenneth Williamson, the associate director of the American Hospital Association, with us.

I know how cooperative you have been over the last few weeks, Mr. Williamson, and the committee certainly is grateful for that cooperation, because it comes from a man we know has a great deal of knowledge on this subject.

STATEMENT OF KENNETH WILLIAMSON, ASSOCIATE DIRECTOR, AMERICAN HOSPITAL ASSOCIATION, AND DIRECTOR, WASHINGTON SERVICE BUREAU

Mr. WILLIAMSON. Mr. Chairman, I am Kenneth Williamson, associate director of the American Hospital Association and director of its Washington service bureau. I am pleased to present this brief statement to the committee expressing the interest of the association in the subject under consideration.

The American Hospital Association is a voluntary, nonprofit membership organization. The great majority of all types of hospitals are included in the membership. Among these are over 90 percent of the Nation's general hospital beds. A substantial number of long-term care facilities are also included in the membership, which in addition to general hospitals, devote a large part of their services to elderly persons.

The American Hospital Association has a long history of interest and activity in behalf of elderly persons. I will not take the time of the committee to detail this history. The association is deeply interested in voluntary health insurance. As the hospitals of the Nation participated in the development of Blue Cross prepayment programs, they foresaw the essential need to give assurances to the public that the use of the Blue Cross insignia, on which is superimposed the seal of this association, could be taken as evidence that certain basic standards were being met. Thus, the annual approval program of Blue Cross plans provides assurances that consideration is given to the welfare of the participants in the plans. We believe such implied guarantees of good faith and sound operation are important to the public.

I would like to interject that I can assure you that this long history was not one of lipservice as characterized by a witness earlier in the day.

The association and its members are, of course, keenly aware of the results of the public's purchase of inadequate health insurance protection. Any substantial inadequacies in insurance benefits become obvious in the payment of hospital bills. If the holder of the insurance policy believes, as they sometimes do, that the insurance was a great deal better than it really is, then their displeasure and even anger may be taken out on the hospital. Thus, the public image of the hospital is not helped.

Hospitals have also been much concerned with the total amount of the premium dollar paid, which is returned to the participants in the form of benefits. There still appears to be a substantial amount of health insurance being sold which returns an inadequate amount in the form of benefits. As hospitals look at this situation, it appears that their services are being used and sold so as to result in inordinately large profits to insurance companies rather than in the payment of hospital services. Here again the end result is hardship to the individual and difficulties for hospitals in the collection of hospital bills. The situation, of course, often is worse where it exists in relation to aged persons because of their limited income and other factors pertaining particularly to the spot.

It is our general observation that as voluntary health insurance has grown it has improved markedly with greater benefits and an increased percentage of the premium dollar being spent for benefits. Group policies are generally found to be superior and the difficulties arise in connection with individual policies. As health insurance for the aged has become a matter of particular public concern in recent years, it may well be that there has been some overly aggressive selling. Apparently, too, some of this newer insurance contains stipulations which are not well understood by elderly purchasers and which clearly would limit the value of the insurance. The American Hospital Association has not made any detailed studies of this overall situation. We do receive general reports which indicate the sort of problems I have mentioned.

The association has been conducting a series of regional conferences jointly with the Department of Health, Education, and Welfare, for the purpose of discussing the Kerr-Mills program. The primary effort of these meetings is to develop a frank exchange of problems and ideas between hospitals, State welfare agencies, and

the Federal authorities which would assist in the improvement and development of the Kerr-Mills program.

In this connection, we have heard discussions as to the limitations of some of the health insurance held by aged persons and difficulties encountered in arranging for payment for services provided. Quite often it appears that the limitations of the insurance are not well-understood by the aged purchaser. The State welfare or other State agencies administering these programs for the indigent and medically indigent aged—namely, Kerr-Mills—may perhaps be able to furnish more details as to the problems presented.

Public education in respect to health insurance is essential. From the problems discussed generally, it would appear that public education and public understanding of health insurance, particularly for the aged, has not yet reached a satisfactory level.

We appreciate the opportunity of presenting these general observations of the American Hospital Association.

Chairman WILLIAMS. Thank you, Mr. Williamson. I wonder if you have any advice to us? We are faced with an obvious need for better understanding and education of people as to what they are buying and what they are getting. We see a lot of fields where consumer education is sadly lacking and we are trying to find ways to sharpen the consumer in what should be his objective in knowing what he is getting, whether it is in the health area, or other areas, too, food, et cetera. Do you have any suggestions for us, any ideas on some educational ways we might approach the consumer problems?

Mr. WILLIAMSON. I wonder whether the private insurance industry has done as much as it might to separate the goods boys from the bad boys in the form, for example, of the possibilities of their developing standard criteria. This might be a listing of basic essentials which should be covered by an equitable health insurance program for the aged, or a hospital insurance program. Such criteria, then, could be promoted widely with what you might call a "Good Housekeeping Seal" awarded the carriers so the public might at least be aware that X policies anywhere in the Nation would pretty well guarantee them some basic essentials and protections.

I think that is one approach which the private insurance people might do more with.

Chairman WILLIAMS. How about the State 65 programs? Does this approach what you are suggesting?

Mr. WILLIAMSON. It does, because you have a group of good reliable companies getting together to promote a product. I think that is basically a good one.

Chairman WILLIAMS. We are getting an additional statement for the record from you; is that correct?

Mr. WILLIAMSON. It is from Mr. Jack Owen, I think, of your State, Senator, who sent a letter in and gave a number of case histories, which, I think, pretty well follow out the things I have said here. It is for the record.

Chairman WILLIAMS. Thank you very much, and, again, for your past aid and cooperation.

(The statement of Mr. Owen follows:)

STATEMENT BY JACK OWEN

Mr. Chairman, my name is Jack Owen. I am the executive vice president and director of the New Jersey Hospital Association which represents 130 member institutions in the State of New Jersey. Ninety of these are voluntary short-term general hospitals and the others are governmental or long-term hospitals.

The New Jersey Hospital Association is interested in this hearing since deceptive or fraudulent claims by small insurance companies not only cause hardship to the individuals purchasing such insurance, but create financial problems for our member institutions and cast suspicion on legitimate insurance carriers.

A quick review of our member institutions revealed problems with seven carriers at the present time. Three of these companies are located in New Jersey, one in Michigan, one in Massachusetts, one in New York, and one in Delaware.

One of the New Jersey carriers has a name similar to a large reputable insurance company and to uninitiated or poorly educated, the resemblance of names causes confusion. To cite a specific example, Mr. Doe was recently hospitalized in one of our member institutions, he informed the admitting desk that he had insurance in one of the large insurance companies for complete hospitalization, and had paid the premiums for the past 2 years. Scrutiny of the policy revealed it was not purchased from a large insurance company but from a small company with a like name and, further, the patient had been paying for a disability policy which paid $15 per week. The patient's bill for hospitalization was $603 for which the insurance paid $27.

In another instance a patient had been paying $124 a year in premium to a small company for "complete" hospitalization. After being hospitalized, the insurance carrier was contacted but refused to respond to either the hospital or the patient. In this case the patient's family eventually settled the hospital bill without ever hearing from the insurance carrier.

In still another case, one of our member institutions filed a claim in November of 1963 which has still not been acknowledged. Repeated letters to the address of the insurance carrier have been returned and phone calls have gone unanswered although premiums can still be paid to the address.

These are specific examples for which names can be supplied and facts supported.

Unfortunately, many patients believe the hospital is collecting from their insurance and attempting to collect from the patient as well for the same bill. When an unscrupulous agent tells a prospective client he will have full coverage for hospitalization and then only pays $10 or $15 and the hospital must collect the rest, the patient doesn't understand why he received an additional bill and frequently places the blame on the hospital, rather than his inadequate insurance coverage.

Mr. Chairman, we are pleased to have had an opportunity to submit this statement at this hearing and are hopeful that for the hospitals, patients, and reputable insurance companies something can be done to discourage deception and fraud in such an important area as health care coverage. Thank you.

Chairman WILLIAMS. We have a lot of other materials that I am going to, without objection, include in the record at this point.

(The material referred to follows; see also p. 185 for further information:)

(Text continues on p. 158.)

STATEMENT ON BEHALF OF ASSOCIATION OF INSURANCE ADVERTISERS

My name is A. Alvis Layne. I have been general counsel for the Association of Insurance Advertisers since 1948. I regret that prior commitments prevented my appearance at the hearing on May 4, 1964. I appreciate very much the opportunity to present this statement on behalf of the association at the invitation of the subcommittee. Because of the limited time available, I have not had an opportunity to clear the content and language of the Statement with each of the association members.

The chairman's letter of April 17, 1964, indicates the subcommittee is interested in facts concerning the regulation and control of advertising and sales practices in the field of health insurance as they may affect the elderly. The chairman suggested that the Association of Insurance Advertisers might be able to furnish information concerning "mail order" solicitations and sales of health insurance, standards for protecting the public from deception, and other pertinent topics. Additional points for comment were suggested by statements made at the hearing before the subcommittee on May 4, 1964.

(1) What is "mail order" insurance?

It is essential, in any discussion of sales techniques in the insurance industry, to distinguish between transactions that fall within the category of "mail order" insurance and those that fall within the more usual agency insurance operation. The form—"mail order" or agency—of the insurance transaction determines not only the means by which the insurance is sold but also to a large extent the type and kind of insurance sold and the jurisdiction of State and Federal regulatory agencies to supervise and regulate the sales practices used.

A "mail order" insurance transaction is one carried out wholly by advertising media such as letters, circulars, newspapers, magazines, and radio or television broadcasts. At no point in a "mail order" insurance transaction does any insurance agent participate. A sales program using letter, newspaper, or magazine advertisements to obtain inquiries from prospective purchasers, to be followed up by an insurance agent, is not a "mail order" insurance program. My definition of "mail order" insurance coincides with the definition adopted by the Federal Trade Commission in its recently promulgated Guides for the Mail Order Insurance Industry.[1]

(2) Is "mail order" insurance unlawful?

Some of the comment before the subcommittee at the May 4, 1964, hearing appears to suggest that "mail order" insurance operations, no matter how fairly and honestly conducted, are "unlawful" and evasions of existing insurance laws. Such suggestions are wholly incorrect.

Since 1897, the Supreme Court of the United States has consistently held than an insurer conducting business through the mails and without the use of agents, although subject to the authority of the State in which the insurer is organized, is not subject to the multiple regulation of other States in which its prospects or policyholders may be resident. The Constitution and laws of the United States forbid these other States to regulate, tax, or prohibit interstate insurance transactions carried out wholly by the use of postal facilities or interstate advertising media (*Allegeyer* v. *Louisiana*, 165 U.S. 578 (1897); *St. Louis Cotton Compress Co.* v. *Arkansas*, 260, U.S. 346 (1922); *Minnesota Commercial Men's Ass'n.* v. *Benn*, 261 U.S. 140 (1923); *Connecticut General Life Ins. Co.* v. *Johnson*, 303 U.S. 77 (1938); *State Board of Ins.* v. *Todd Shipyards Corp.*, 370 U.S. 451 (1962)). *Todd Shipyards* makes clear that regulation of "mail order" interstate insurance transactions, in addition to regulation by the State in which the insurer is located, must come from Federal authority and not from a multiplicity of State authorities. "Mail order" insurance transactions are subject to the supervision and jurisdiction of the Federal Trade Commission with respect to unfair, misleading, or deceptive practices (*Federal Trade Commission* v. *Travelers Health Ass'n.*, 362 U.S. 293 (1960)).

Insurers selling and servicing their policies through agency operations are subject to the regulation of each State in which agents are maintained. Under existing law, agency insurance operations are, however, not subject to regulation or supervisions by existing Federal authority as to misleading or deceptive sales practices (*Federal Trade Commission* v. *National Casualty Co.*, 357 U.S. 560 (1958)). Agency sales methods (agents combined with various advertising techniques) are the usual and generally the more successful method of merchandising insurance. This fact probably accounts in part for the claims frequently made—including the claims in some of the testimony to this subcommittee—that the agency system is the "orthodox" and "ethical" way to sell insurance.

There are some State insurance authorities who seek the power to proscribe all such interstate transactions regardless of the value of the insurance or the

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[1] "The industry for which these guides have been established is comprised of the persons, firms, corporations, and organizations engaged in the sale or offering for sale of insurance of any kind in commerce by means of the U.S. mails in any State in which they are not licensed to conduct the business of insurance or in which, though licensed, they do not have any agents. The guides are applicable to all advertising and sales promotions of insurance sold under such circumstances" (Federal Register, May 15, 1964, p. 6381).

honesty and fairness of the insurer. Thus far, these authorities have not been successful.

As the cases cited above suggest, some State regulatory authorities have claimed repeatedly that "mail order" insurance transactions should be regulated not only by the State in which insurer is located and by Federal authority but also by the several States in which prospective policyholders are resident. The claim by these State insurance authorities is and has been that each interstate insurance transaction must be subject to multiple State regulation and control and not subject to regulation or supervisions by any agency of the Federal Government.

This position taken by some State insurance commissioners gives rise to their assertion that "mail order" insurance is "unauthorized," "unregulated," and "unlawful." To these State authorities "mail order' insurance is "unauthorized" and "unregulated" because each transaction is supervised and regulated by a single State and the Federal Government rather than by multiple States; "mail order" insurance is "unlawful" because these State authorities refuse to recognize existing decisions of the Supreme Court sustaining such transactions and because these State authorities are attempting to obtain, and in some instances have obtained, State legislation to declare a "mail order" method of merchandising insurance a crime regardless of the fairness of the advertising or the value of the policies sold.

(3) *Is "mail order" insurance something new? How much is sold?*

"Mail order" insurance operations have been conducted in the United States for at least 75 years and probably much longer. Some "mail order" insurers have been in the business for more than 75 years. "Mail order" insurance, however, accounts for a relatively small part of total insurance sales.[2] A very small amount of fire and casualty insurance is solicited and sold by mail. In the field of personal (life, health, and accident) insurance, "mail order" insurance certainly accounts for less than 1 percent of total insurance sales. In the area of particular interest to this subcommittee—sales to elderly persons—"mail order" insurance would, in my opinion, amount to a small fraction of 1 percent. I know of no situations—and none have been called to my attention either by members of the association or by State or Federal authorities—suggesting that there is any particular problem in connection with or emphasis on "mail order" insurance sales to the elderly.

"Mail order" insurance is usually limited either in the scope of the coverage offered or in the type or identity of the persons to whom policies are offered for sale. Policies may cover only travel accidents or boating accidents, for example, or may be sold only to members of particular organizations such as church, fraternal, and other groups. The limitations in scope of coverage and the persons to whom such policies are sold reflect both the advantages and the limitations inherent in the "mail order" method of merchandising insurance. Solicitation by mail and advertising media makes possible contact with persons interested in or qualified for the limited policy offered for sale. "Mail order" solicitation, moreover, makes possible a widespread geographical distribution of specialized risks. "Mail order" solicitation also makes possible economical solicitation of small premium, limited coverage insurance policies not sold or economically feasible for sale through personal solicitation of an insurance agent. "Mail order" solicitation is not useful or productive in the sale of large, expensive coverages tailored to the needs and pocketbook of a particular insured or risk to be covered. "Mail order" insurance operations cannot—and do not—compete with agency operations when the amount of premium involved makes the agent's sales efforts worthwhile.

(4) *Are there existing regulations and controls to prevent and to punish deception and fraud in "mail order" insurance?*

The testimony before the subcommittee on May 4, 1964, suggests that the extent to which the practices of "mail order" insurers are presently subject to extensive regulation and supervision by both State and Federal authorities may have been overlooked. The fact is that a "mail order" insurance transaction is subject not only to State but also to Federal law. In addition, the "mail order" insurance industry has for years been active in seeking the elimination of questionable, misleading, and deceptive practices.

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[2] This does not include reinstatements and renewals of existing policies, the sale of group insurance or the sale of specialized casualty coverages by agency companies using "mail order" methods of solicitation.

Every "mail order" insurer is subject to the regulation of at least one State insurance department. There is no indication that "mail order" insurers are concentrated in a particular State or States in which State regulation may be weak or corrupt. On the contrary, "mail order" insurers are located widely throughout the United States. There are "mail order" insurers located in New York, Pennsylvania, Illinois, Indiana, Missouri, Minnesota, Nebraska, Texas, and Arizona, among others. I have never heard it claimed that a "mail order" insurer offered a different, less desirable policy in other States than it did in its home State—or that the company circulated outside of its home State advertisements different than those used at home. I know of no reason to suppose that any State authority would permit any citizen of any State to be bilked or defrauded.

Every "mail order" insurer is subject to the provisions of the Federal Trade Commission Act, title 15, U.S.C., section 41, et seq.; *Federal Trade Commission* v. *Travelers Health Ass'n, supra.* The extent to which the Commission is actively carrying out its responsibilities in this field is demonstrated by the testimony of the Commission's representative before this subcommittee.

Every "mail order" insurer is subject to proceedings before the Post Office Department to prohibit the use of the mails by persons obtaining money through the mails by fraudulent representations (39 U.S.C., sec. 4005). In addition to administrative proceedings, any "mail order" insurer using the mails to defraud is subject to heavy criminal penalties (18 U.S.C., sec. 1341). The Post Office Department has effectively demonstrated that the statutory penalties will, in fact, be brought to bear on any "mail order" insurance operation engaging in fraudulent practices. Read, for example, *United States* v. *Sylvanus*, 192 F. 2d. 96 *cert. denied*, 342 U.S. 943, (1951); *United States* v. *Minnec*, 104 F. 2d. 575, *cert. denied*, 308 U.S. 577 (1939); *United States* v. *Littlejohn*, 96 F. 2d. 368, *cert. denied*, 304 U.S. 583, (1938).

The "mail order" insurance industry has itself been active in promoting the enforcement and observance of fair practices. The Association of Insurance Advertisers was created in 1948 as a means of self-regulation of "mail order" insurance advertising practices. In 1948, the members adopted a code of advertising rules and directed the general counsel of the association to review advertising of members companies. Members not in compliance with the rules are suspended and expelled from the association.

The Association of Insurance Advertisers has also enlisted the support and interest of other agencies, including the Federal Trade Commission, in regulating the advertising practices of "mail order" insurance companies. In 1948, the association applied to the Federal Trade Commission for a trade practice conference to promulgate rules governing the advertising and sales promotion practices of mail order insurance. Rules were issued in 1950. The AIA also participated when the Federal Trade Commission subsequently promulgated expanded rules in this field.

(5) Do "mail order" insurers pay just claims? How can a policyholder collect a claim from a "mail order" insurer?

Implicit in some of the testimony before this committee are the assertions that "mail order" insurers do not pay just claims of their policyholders and that if "mail order" insurers refuse to pay just claims the policyholder has no reasonable, effective way to collect. These assertions are wholly false in fact and in law.

I know of no case in the past 10 years in which it was claimed by any responsible person that a "mail order" insurance company was as a matter of practice refusing to pay just claims. All direct mail companies of which I have any knowledge pay their just claims, promptly and in full. No evidence to the contrary has, to my knowledge, ever been brought forward. Obviously, there are times when disputes arise over individual claims. It has been my experience that, in instances where a particular claim has been questioned, the matter has been satisfactorily worked out. It is impossible to believe that a "mail order" insurer that refused to pay claims could survive even for a brief time in view of the formidable arsenal of State and Federal prosecutions that would be invoked.

But how about the individual policyholder dissatisfied with a particular claim? What can he do?

Every State of the United States has legislation authorizing a policyholder to sue in his home court any "mail order" insurer in any dispute over the policy. The policyholder need not go to some foreign state. His own courts are available to him. The constitutionality and effectiveness of these statutes has been sustained by the Supreme Court of the United States in *Lulu B. McGee* v. *International Life Insurance Co.*, 355 U.S. 220 (1957).

Despite these statutes and the Supreme Court's decision sustaining them, a number of State insurance authorities continue to represent to the public that a policyholder may not be able to collect just claims from a "mail order" insurer. These representations are false. They serve only to encourage policyholders to cancel insurance protection which, because of age or condition of health, the policyholder may be unable to replace or replace only at a much higher cost. It is now the current practice of some of these authorities to suggest that, even if the "mail order" insurer can be sued by a policyholder in the event of a dispute, the "mail order" company will not pay the judgment. This is the sheerest sophistry. I know of no instance in which any "mail-order" company refused to pay a valid judgment. Assertions that an insurer will not or may not pay just claims and judgments obviously destroy the essential foundation of an insurance company's business, policyholder's confidence in the insurer's financial integrity. Fairness to both the insurer and its policyholders would dictate that at least some instances in which "mail-order" insurers refused to pay valid judgments be specified as a basis for the charge or insinuation that "mail order" insurers "may" not pay a claim or a judgment.

(6) *Why don't "mail order" insurers obtain licenses and comply with the insurance regulations of the States? Do "mail order" insurers avoid multiple State regulations of the States? Do "mail order" insurers avoid multiple State regulation in order to be free to prey upon the general public, including the elderly?*

It is not possible for "mail order" insurers to become licensed in every State because of both economic and legal barriers.

"Mail order" insurance must be offered to a large number of persons over a wide area. It is realistically possible to market a policy covering boating accidents, for example, only by contacting all persons engaged in boating wherever located. In the case of those companies or policies limited to particular groups—as, for example, church workers—there may be relatively few eligible prospective policyholders. Nearly every State has some form of compulsory countersignature law requiring the use of local agents to countersign policies. Some 22 States, in addition to requiring that an agent sign every policy, require the insurer to pay the agent a minimum commission whether or not the agent had any connection with the sale of a particular policy. These State laws obviously are designed for application to the usual agency method of operation. Application of these statutes to "mail order" insurance transactions would effectively forbid this means of merchandising insurance. The type and kind of policy sold by "mail order" insurers is generally not suitable for sale through an agency system of merchandising. The small size of the premium generally involved makes sales efforts by agents economically unfeasible and unattractive. After all, an agent can just as easily and more profitably spend time soliciting the sale of a policy carrying a premium of a hundred dollars or more rather than the small premium usually involved in a "mail order" insurance transaction.

Multiple licensing and State regulation is a substantial expense for any insurer. For a small company the cost of multiple State regulation can be so excessively high, in relation to the amount of premiums to be obtained from the States involved, that it would in most cases be better for the company to forego the business entirely than to subject itself to such regulation. These costs include the expense of filing additional annual reports, the multiple financial and policy requirements, the expense of reconciling varying and conflicting regulations and statutes inherent in any multiple and overlapping regulatory system.

The conflicting and inconsistent State laws regarding surplus and capital requirements for insurance companies prohibit a number of "mail order" insurance companies from becoming licensed in multiple States. The form of corporate organization of some well-established "mail order" insurance companies is proper in their home States but not permitted in certain other States. These difficulties are made more complex by a maze of "retaliatory" statutes among the States. I should note that I have never heard of a "mail order" insurer going into receivership or becoming involved in financial difficulties that impair its ability to pay every just claim.

These economic and regulatory handicaps are real. In *Todd Shipyards*, cited above, the Supreme Court noted:

"But the policy announced by Congress in the McCarran-Ferguson Act was one on which the industry had reason to rely since 1897, when the *Allgeyer*

decision was announced; and *we are advised by an amicus brief how severe the impact would be on small insurance companies should the old rule be changed*" (p. 457). [Emphasis supplied.]

The "amicus brief" referred to by the Supreme Court was filed by Church Fire Insurance Corp. and the Catholic Relief Insurance Co. of America. This brief stated:

"The amount of insurance business done by Church Fire and the Catholic Relief Insurance Co. is of necessity limited by the size of the Protestant Episcopal Church and the Roman Catholic Church and the amount of property owned by their component organizations.

"In addition to being licensed in New York, Church Fire in 1960 was licensed as a foreign insurer in 23 States (including Texas) where the volume of business done and the scope of its activities have made qualification appropriate. In addition it issues policies covering church properties in each of the remaining 26 States in which it is not licensed. * * * The Catholic Relief Insurance Co. is licensed to do business only in Nebraska. Although it writes insurance covering church properties in 167 dioceses and religious orders in 32 States (including Nebraska), the volume of its business and the scope of its activities have not as yet been sufficient to warrant qualification as a foreign insurer in any State. * * *

It is not unrealistic to expect that the States in which Church Fire and the Catholic Relief Insurance Co. are not now licensed would be quick to exercise additional taxing and regulatory powers granted to them as the result of a decision in favor of Texas in this case. Church Fire and the Catholic Relief Insurance Co. could not afford to continue issuing policies on church properties in these States on the basis of their present premium income if they are subjected to the jurisdiction of these States solely because of the presence in the States of the risks insured. * * *

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"The consequences of such a result would fall particularly heavy on the small insurance company. As noted above, Church Fire and the Catholic Relief Insurance Co. would not be able to support the heavy burden of ascertaining and complying with the requirements of the States in which they are not now licensed, and would be effectively precluded from continuing to write insurance on church properties in those States. The growth and development of other small insurance companies not limited as are Church Fire and the Catholic Relief Insurance Co. in their potential for expansion would be seriously restricted by the burden of such compliance. The large insurance companies which are licensed and active in all 50 States would thereby receive a further competitive advantage in addition to those they already possess by virtue of their size."

Finally, I should like to point out that the "mail-order" insurance companies have not opposed and do not oppose State regulation designed to protect the public. "Mail-order" insurers have opposed and do oppose State regulations and statutes designed to drive them out of business. As long ago as 1949, a form of limited licensing bill was suggested to the National Association of Insurance Commissioners. The bill is designed to allow "mail-order" insurers to become licensed in every State and still remain in business. The Association of Insurance Advertisers repeated this suggestion in 1959. So far as I am aware, the suggestion has never been acted upon by the National Association of Insurance Commissioners. A copy of the suggested limited licensing bill is attached for the committee's convenient reference.

"Mail-order" insurance is an established and honorable segment of the insurance business. "Mail-order" insurance solicitation is an effective and efficient method of merchandising insurance under limited circumstances. The insurance is useful to many insureds; the companies are regulated and the public is fully protected. There is no greater likelihood of fraud, misrepresentation, or deception of elderly persons in "mail-order" insurance transactions than in any other method of merchandising insurance. There are existing, effective statutes and regulations at both the State and Federal levels of Government to prevent fraud and misrepresentation and to prosecute any such practices if attempted by a "mail-order" insurer.

A BILL FOR AN ACT EMPOWERING THE (COMMISSIONER OF INSURANCE) TO ISSUE PERMITS TO DIRECT-SELLING INSURERS TO SOLICIT AND SERVICE RESIDENT POLICYHOLDERS BY ADVERTISING MEDIA

SECTION 1. Definition of Direct-Selling Insurer.

A direct-selling insurer as used in this Act means any insurer which (1) is organized or exists under the laws of any other State (referred to in this Act as the domiciliary state), (2) has no offices or agents in this state and solicits residents of this state to apply for, purchase or renew policies only through advertising media, and (3) is subject to the supervision of the agency or officer having jurisdiction of the insurance business in the domiciliary state.

SECTION 2. Issuance of Permit to Direct-Selling Insurer.

Every direct-selling insurer shall apply to the (Commissioner of Insurance) of this state for a permit under this Act before soliciting residents of this state, through advertising media, to apply for, purchase or renew policies. Such application shall be accompanied by

(1) a written power of attorney appointing the (Commissioner of Insurance) of this state and his successors in office as the agents of such insurer to make binding acceptance of service of lawful process, in the manner provided in and subject to the requirements of (cite local statutes having to do with Service of Process on authorized foreign insurers), which process is issued in any action, suit or proceeding instituted in any court of competent jurisdiction in this state by or on behalf of any resident insured or beneficiary upon any claim originating against such insurer while such permit or any renewal thereof is in force, or based on any policy issued to any such resident insured during any such time;

(2) a copy of such insurer's charter, articles of association, or constitution, and its bylaws if the same purport to bind the insurer's policyholders, certified to by the officer or agency having supervision of such insurer in the domiciliary state;

(3) a sworn statement showing the address of the insurer's principal office in the domiciliary state, the names and addresses of its officers and directors, and its current financial condition;

(4) a copy of its last annual statement and of its last official examination report certified to by the officer or agency having supervision of such insurer in the domiciliary state; and

(5) a certificate of the officer or agency having supervision of such insurer in the domiciliary state certifying (a) that such insurer is lawfully organized under the laws of the domiciliary state and in its operations is complying with such laws, including applicable laws relating to minimum financial requirements, and is currently authorized to conduct its business by the domiciliary state, and (b) that its policy contracts comply with the laws of the domiciliary state, and, if such laws so require, have been filed with and/or approved by such officer or agency.

Before granting a permit under this Act the (Commissioner of Insurance) of this state may also require submission of policy contracts to be issued to residents of this state for approval by him, if the domiciliary state has not approved the same. Upon approval of such application, the (Commissioner of Insurance) shall grant a permit hereunder. Each original permit granted under this Act shall be renewable on the ____ day of _____ next following its issuance, and annually thereafter on the same date in each succeeding year, all in the manner and upon the conditions set out in Section 5 of this Act.

SECTION 3. Scope of Permit.

Any direct-selling insurer having in force a permit under this Act, or any renewal thereof, may by virtue of such permit enter this state to investigate claims originating in this state or arising under policies held by insured or beneficiaries residing in this state, or to defend, without conditions precedent other than those imposed on insurers organized under the laws of this state, any action, suit or proceeding in which the (Commissioner of Insurance) of this state has or

thereafter may accept service of process under the power of attorney provided for in Section 2(1) of this Act; but no such permit or any renewal thereof shall be deemed to authorize any such insurer to maintain offices or use soliciting agents in this state, or to solicit insurance business or renewals thereof from residents of this state through any means other than advertising media, and any such insurer doing so without complying with all other laws of this state applicable to other foreign insurers engaged in like kinds of insurance business, shall be subject to the penalties provided under such other laws for engaging in such activities in this state without authority.

SECTION 4. Fees and Gross Premium Tax Payable by Insurer.

Each direct-selling insurer applying for and receiving an original permit under this Act shall pay to the (Commissioner of Insurance) of this state a fee of $_____, and shall be deemed to have consented to the payment of a tax based on gross direct premiums collected by such insurer from residents of this state during the period such permit or any renewal thereof is in force. The percentum used to measure such tax shall be the same as that used in measuring the tax collected from other nonresident insurers engaged in like kinds of business under the laws of this state. In determining the gross amount of direct premiums upon which such tax is based ,there shall be excluded (1) all premiums returned to such residents on account of cancellations or reductions in rates or benefits, (2) all dividends paid to such residents, or applied to the reduction of premiums of such residents, and (3) all dividends held for the benefit of such residents. Such tax shall be payable to the (Commissioner of Insurance) of this state at the time of each renewal of such permit as provided in Section 5 of this Act.

SECTION 5. Renewal of Permit.

Every direct-selling insurer shall annually apply to the (Commissioner of Insurance) of this state for a renewal of any permit held under this Act, and such application shall be accompanied by

(1) a sworn tax return showing the gross premiums collected by such insurer from residents of this state since the date of issuance of the original permit or the last renewal thereof, whichever is later, and the amounts claimed to be excludable therefrom under the provisions of Section 4 of this Act;

(2) payment of the amount of the gross premium tax computed as provided in Section 4 of this Act and shown to be payable by such return;

(3) a sworn statement showing any changes in (a) the address of the insurer's principal office, (b) in the names and addresses of its officers and directors, and (c) its financial condition;

(4) a copy of its last annual statement and any official examination report not previously filed, certified to by the office or agency having supervision of such insurer in the domiciliary state;

(5) a current certificate of the office or agency having supervision of such insurer in the domiciliary state, certifying (a) that such insurer is currently lawfully organized under the laws of the domiciliary state and in its operation is complying with all such laws, including applicable laws relating to minimum financial requirements, and (b) that such insurer is currently authorized to conduct its business by the domiciliary state; and

(6) copies of any amendments to the insurer's charter, articles of association, constitution, or bylaws if the bylaws purport to bind the policyholders, effected since the granting of the original permit or the last renewal thereof, whichever is later, certified to by the officer or agency having supervision of such insurer in the domiciliary state.

Upon approval of such application by the (Commissioner of Insurance) of this state, a renewal of the permit shall be granted unless it appears that there exists one or more of the grounds for a refusal thereof as set forth in Section 8 of this Act, in which event the (Commissioner of Insurance) of this state shall proceed as provided in such latter section.

SECTION 6. Manner of Serving Process on the (Commissioner of Insurance) of this state.

Service of process on the (Commissioner of Insurance of this state) by virtue of the power of attorney filed by a direct-selling insurer pursuant to Section 2(1) of this Act shall be made under and by virtue of the provisions of Chapter ____ (here cite provisions of local statutes having to do with Service of Process on authorized foreign insurers).

SECTION 7. Scope of the Act; Inapplicability After Termination of Permit.

(1) The provisions of this Act shall apply to a direct-selling insurer only so long as such insurer (a) has in force a permit granted hereunder, or a renewal thereof, and (b) confines its activities in this state to those stated in Sections 1 and 3 of this Act and authorized under such permit.

(2) From the time such permit or any renewal thereof has expired without being further renewed, or has otherwise terminated, a direct-selling insurer shall be subject to the laws of this state which are applicable to other foreign insurers engaging in like kinds of insurance business, to the extent that the manner in which such insurer thereafter conducts its business activities in this state shall warrant the application of such other laws under the Constitution of the United States and of this state; but, the investigation of any claim which may form the basis of an action, suit or proceeding in respect of which the (Commissioner of Insurance) of this state may accept service of process under the power of attorney provided for under Section 2(1) of this Act, or the defense of any such action, suit or proceeding in which the (Commissioner of Insurance) of this state may accept service forth in Section 8 of this Act, in which event the (Commissioner of Insurance) of this state shall proceed as provided in such latter section.

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SECTION 8. Refusal of Renewal or Revocation of Permit.

After reasonable notice to the insurer and an opportunity to be heard, the (Commissioner of Insurance) of this state may refuse to renew a permit granted to a direct-selling insurer under the provisions of this Act, or may revoke any such permit or any renewal thereof theretofore granted, upon the grounds that the insurer has

(1) engaged in an activity in this state beyond the scope of such permit; or

(2) sold to residents of this state, or solicited residents of this state to purchase, any policy contract which has not been approved by the officer or agency having supervision of such insurer in the domiciliary state if the laws thereof so require, or which has not been approved by the (Commissioner of Insurance) of this state in the event that the laws of the domiciliary state do not require such approval and the (Commissioner of Insurance) of this state has required such policy contracts to be approved by him; or

(3) pursued unfair claim practices by refusing to pay its just claims to residents of this state in accordance with the provisions of the policies involved and the facts before the insurer, or by unduly delaying the payment of such just claims; or

(4) failed for a period of thirty days to satisfy a final judgment, decree or order of any court rendered against such insurer in any court of competent jurisdiction in this state; or

(5) failed to comply with any of the laws of the domiciliary state applicable to the operation of its business, including those relating to minimum financial requirements; or

(6) become insolvent or is undergoing voluntary or involuntary dissolution or liquidation; or

(7) had its authority to conduct business in the domiciliary state revoked or otherwise terminated.

(NOTE.—If the "Unauthorized Insurers Process Act" has been adopted by the state, the following section should be included in this Act.)

SECTION 9. Direct-Selling Insurer not Having a Permit.

Any direct-selling insurer not having a permit under this Act and not authorized to do business in this state under any other laws relating to foreign insurers, shall be subject to the provisions of (make appropriate reference to the state's "Unauthorized Insurers Process Act").

STATEMENT OF LEISURE VILLAGE, LAKEWOOD, N.J.

Leisure Village is a retirement community presently under development in the township of Lakewood, Ocean County, N.J. The project is being developed under the condominium concept of real property ownership and occupancy of the garden-patio-type apartment units is restricted to senior citizens of the age of 55 years or older, with certain well-defined exceptions.

It has come to the attention of Leisure Village that your committee has been investigating various problems confronting our elderly citizens particularly in the area of fraudulent and misleading practices. Specifically, Leisure Village is concerned with that facet of your inquiries dealing with medical and health insurance plans affecting senior citizens, the manner in which membership in these plans is solicited and the substance of the plans.

Recent newspaper articles reporting the proceedings of your committee have included a portion of the text of the testimony of Mr. Robert R. Peacock, secretary-director of the New Jersey Real Estate Commission. It appears that Mr. Peacock testified before your committee on May 4, 1964, and that the entire gist of his testimony dealt with the medical plan offered by Leisure Village to its residents. The context in which Mr. Peacock's testimony appears in these various newspaper articles leads almost inescapably to the conclusion that Leisure Village and the medical plan offered by it are to be viewed with a considerable amount of skepticism. It is noted that Mr. Peacock's testimony itself suggests such a conclusion and the language of the various articles in conjunction with comments attributed to other witnesses, permits of no other reasonable interpretation.

The medical plan covering the residents of Leisure Village is written by Continental Casualty Co. of Chicago, Ill. Leisure Village selected the Continental Casualty plan for the reason that it presented the most extensive coverage for the amount of the premium required. Exhaustive investigation over a period of approximately 2½ years was conducted by Leisure Village of medical plans offered by many other insurance companies. This investigation also extended to the policies in effect at other retirement communities throughout the Nation.

Most of these plans, either in effect or contemplated, were rejected by Leisure Village for the reason that they did not appear to offer adequate coverage and protection to senior citizens or required excessive premiums for the coverage which our investigations revealed to be most desired by individuals living in planned retirement communities. While the Continental Casualty medical plan applicable to residents of Leisure Village does not insure against inpatient hospital expenses, surgical expenses and certain other costs and expenses incident to the treatment of illness and disease, the policy was not designed for those purposes. Our studies indicate that the retired individual, or those persons approaching retirement age, are very definitely concerned with the steady drain on their financial resources by reason of doctors' visits, prescription drugs, and other minor expenses. The plan in effect at Leisure Village was designed for the purpose of reducing the financial burden upon its

residents, not to the point that all of these costs and expenses would be eliminated, but to the point where they would not constitute a major concern. In fact, Mr. Walter Young of the New Jersey State Department of Banking and Insurance remarked at the meeting of November 21, 1963, to which Mr. Peacock referred, that the Continental Casualty medical plan in effect at Leisure Village was a good plan and gave a very fair return for the premium required.

We fully appreciate the desire of this committee to inform itself about irresponsible fraudulent and misleading practices affecting our aged. Leisure Village is prepared to cooperate to the fullest extent any way possible to assist this committee to achieve its goals. At the same time, Leisure Village would have it clearly understood that it is an honest, legitimate developer very definitely concerned with giving honest value to its residents and prospective residents. To this end, we strongly resent any inferences or innuendos to the contrary appearing in the testimony before your committee and in news releases of such testimony. The integrity of the principals of Leisure Village and their reputation for giving dollar-for-dollar value is well established in New Jersey and has been so established for many years. Certainly, Continental Casualty Co. has also long been recognized nationally as one of the "better commercial insurers."

Leisure Village desires to go on record before this committee in answer to the statement of Mr. Peacock made on May 4, 1964. Specifically, in referring to the meeting held at Mr. Peacock's office between members of the New Jersey State Department of Banking and Insurance and officials of Leisure Village, including myself, Mr. Peacock stated before this committee that "at the time of this (meeting) the Continental Casualty policy in question had not yet been approved by the department of banking and insurance, even though many might have been led to believe otherwise by reading the Leisure Village ads and brochures."

The facts do not support Mr. Peacock's testimony. We have in our file a letter dated October 17, 1963, from the Continental Casualty Co. addressed to Mr. Walter Young, associated actuary of the department of banking and insurance, Trenton, N.J., submitting as an enclosure to this letter, the group master policy which was proposed to be issued to Leisure Village. This same letter bears the stamp of the New Jersey State Department of Banking and Insurance dated October 24, 1963, and signed by Walter Young, associate actuary, attesting to the filing of the group master policy with the department. The acceptance and filing of such a policy with the department of banking and insurance constitutes approval of the plan by the department. The original plan submitted was, therefore, approved approximately 1 month before the meeting to which Mr. Peacock refers. Subsequent to the approval of the initial plan filed with the department, some very minor changes were made in the policy by Continental Casualty Co. at the request of Leisure Village officials for the purpose of more closely satisfying the individual needs of the residents of Leisure Village. These amendments were submitted by Continental Casualty Co. to the commissioner of banking and insurance of the State of New Jersey by letter dated January 10, 1964, and were filed and approved on January 15, 1964. We have documentary evidence in our files of these filings.

It should, of course, be noted at this point, that the plan presently in effect at Leisure Village was studied quite extensively by the New Jersey State Department of Banking and Insurance prior to approval.

We observe that Mr. Peacock made reference to the fact that Leisure Village was the first project of its kind in New Jersey being developed under the condominium legislation signed by Governor Hughes in December 1963. We also note that Senator Fong questioned Mr. Peacock concerning State regulation of condominiums.

The medical plan in effect at Leisure Village is completely unrelated to the fact that Leisure Village is also a condominium. While the concept is new to New Jersey it does not follow that "there are a lot of headaches ahead for New Jersey," as Senator Fong is reported to have commented. Furthermore, the context in which Senator Fong's remarks appear in certain news releases also lead to the inference that the integrity of Leisure Village and its principals is questionable. While it is always necessary to be on guard against shady operators, it is absolutely unnecessary to impute dishonest conduct to one not guilty of it. It does not at all follow as suggested by Mr. Peacock that future condominiums, or even future conventional retirement communities will create problems for the government if a health plan is offered to the residents in a "package deal."

Parenthetically at this point, Leisure Village extends a most cordial invitation to all of the members of this committee to visit and inspect the Leisure Village community in Lakewood, N.J., at the convenience of the committee or of any of its members. We invite you to talk with our residents and to our officials. We also invite you to inspect our files to determine the extent to which Leisure Village has studied the needs and desires of senior citizens and how we have been able to reduce these needs and desires to reality for the pleasure, protection, benefit, and enjoyment of our residents.

We, of course, have no knowledge of many of the alleged facts upon which Mr. Peacock bases some of his statements. Many of the statements are Mr. Peacock's own conclusion, which, of necessity, are a matter of personal opinion and are not always factually well founded. Mr. Peacock refers to his statement to a section of an advertisement of Leisure Village wherein the following statements were made:

"To enjoy your fun to the utmost at Leisure Village, you should have frequent medical checkups for your continuing good health. And Leisure Village provides just that."

"Right on the grounds there will be a complete medical building in which general practitioners and specialists will have their own offices. You also get a group medical plan with comprehensive coverage including drugs and at-home visits by doctors."

"Big news: These services are all included in the easy monthly maintenance charge on the beautiful garden-patio apartment you own."

The medical plan covering Leisure Village residents does provide comprehensive coverage and, following a $50-deductible amount, will pay for 75 percent of includable expenses. These includable expenses cover doctor's visits at home and at the doctor's office whether for treatment or for medical checkup. Furthermore, the monthly premium for the medical plan of $6 per person is, in fact, included in the monthly maintenance charge paid by the homeowner. It should also be noted at this point, that membership in the group plan is voluntary and anyone who does not choose to belong, is, of course, not charged the $6 monthly premium. Approximately 95 percent of those persons residing in Leisure Village do choose to be members of the medical plan.

The promotional literature including brochures distributed by Leisure Village did mention that a medical plan was available and did point out some of the more important features of the plan. This plan was and is a "bargain." There are few plans in existence which offer as much for the amount of premium involved. However, no claim has ever been made that this bargain is phenomenal as Mr. Peacock has concluded even though many people might consider the plan to be a phenomenal bargain.

Mr. Peacock irresponsibily charges that Leisure Village was initially reluctant to cooperate with the officials of the Department of Banking and Insurance. To the contrary, the language of the note which was added to the Leisure Village promotional brochures, the contents of which are set forth in Mr. Peacock's testimony, was agreed to at the same meeting at Mr. Peacock's office on November 21, 1963. The purpose of this explanatory note was not to "clarify the real health benefits which were to be provided" but to point out what would not be provided. The agreement of Leisure Village to add this explanatory note to its brochures was the result of its consistent policy of giving honest value.

We would like to close our statement with the request, not only for our protection and the preservation of our reputation but also for that of all reputable firms having contact with our elderly, that this committee, in the future, consider only the facts of a particular case and not permit conclusory comments to be expressed by witnesses. Frequently, irresponsible and defamatory statements are made which do incalculable damage to those who least deserve it. We appreciate the fact that a legislative inquiry frequently must go beyond the mere facts of a particular matter. However, we believe that extreme caution should be taken to insure that innocent parties are not either directly or indirectly stigmatized by unjustified opinion.

We thank you for the opportunity you have provided us.

JOHN R. RUTLEDGE, Jr.,
Attorney for Leisure Village, Inc.

Chairman WILLIAMS. I believe that concludes the afternoon session. This has been a full and highly productive day and every witness that has appeared I have found to be exceptionally well qualified and most helpful.

We will adjourn until further notice.

(Whereupon, at 3:55 p.m., the committee adjourned, subject to the call of the Chair.)

STATE OF OHIO,
DEPARTMENT OF INSURANCE,
Columbus, June 18, 1964.

Hon. HARRISON A. WILLIAMS, Jr.,
Chairman, Subcommittee on Frauds and Misrepresentations Affecting the Elderly, U.S. Senate, Washington, D.C.

DEAR SENATOR WILLIAMS: In response to your letter of June 2, in which you ask seven questions concerning the statement prepared by Director William R. Morris and presented by Commissioner T. Nelson Parker at the recent hearing conducted by your subcommittee, I am happy to offer the following information.

Question 1. "On the first page of Commissioner Morris' statement, he says that he had not had time to poll the membership on the extent of mail-order activity in each individual State. Does any such poll exist now"?

The members of the NAIC have not been polled for this purpose. Rather than ask each of the 50 State insurance commissioners to develop such statistical data for their respective States, and in view of the brief time available for the preparation thereof, my staff and I have undertaken the task in behalf of NAIC. The findings appear below in the response to the second of your questions.

Question 2. "The statement says 'it has been estimated that the amount of direct-mail health insurance is probably less than 1 percent of the total health insurance market in the United States.' May we have details on how that estimate was reached"?

A review of the annual statements, submitted by all insurers to the State insurance commissioners, indicates that the total premium volume of health insurance issued by insurance companies during 1963 was $6,431,124,200. The total premium volume of health insurance issued by direct-mail insurers during the same period was $44,326,096. This latter figure was also taken from annual statements of the companies which issue health insurance on a direct-mail basis. Thus, a little less than seven-tenths of 1 percent of the total premium volume of health insurance written by insurance companies during 1963 was sold on a direct-mail basis.

It should be noted that neither of the above premium volume amounts include Blue Cross and Blue Shield. If the premium volume of Blue Cross, Blue Shield, and other hospital-medical plans were included, the $6,431,124,200 figure would be increased by over $3 billion, without an increase in the $44,326,096 figure (since such plans are not written on a direct-mail basis), thereby reducing the proportion from seven-tenth of 1 percent to below one-half of 1 percent.

Question 3. "The statement says that the NAIC has developed a comprehensive advertising code and has coordinated the contents of such code with the advertising standards of the Federal Trade Commission. May we have copies of these codes for our files and possible inclusion into the hearing record"?

A copy of the NAIC advertising rules, and the interpretive guide relating thereto, is attached.

Question 4. "The statement mentions that the NAIC had a conference in Phoenix last autumn. Do you have any summary of this meeting, or a prospectus for your June meeting"?

A copy of the report of the advertising of insurance committee presented at the Phoenix meeting is attached hereto. In addition, we are attaching a copy of the joint statement by the NAIC and the FTC referred to in the minutes of the meeting.

Attached hereto is a report of the meeting of the advertising of insurance committee held in Minneapolis on Tuesday, June 9, 1964.

Question 5. "May we have a report on the findings of your March meeting of zone II"?

The meeting on unlicensed mail order insurance companies held at the annual meeting of zone II, NAIC on March 23, 1964, in Columbus, Ohio, consisted of discussions of three aspects of the subject. The discussion concerned various means at the disposal of insurance departments to control illegal activities in which these companies may engage.

William F. Austin, immediate past chief insurance commissioner, South Carolina, discussed the joint principles recently promulgated and agreed to by the FTC and the NAIC. Mr. Austin headed the NAIC committee which handled this project.

James S. Reece, chief law enforcement officer, Ohio Department of Insurance, outlined certain means used by that department in meeting the problem created by unlicensed companies. These measures were treated in detail in Mr. Morris' statement to the committee.

John P. Gorman, Chicago attorney, discussed possible problems of constitutional law arising out of the use by the States of the various weapons at their disposal. Mr. Gorman concluded that decisive and effective action can be taken against unlicensed mail-order carriers without running afoul of the Federal Constitution.

He predicted that the dictum of Chief Justice Marshall that the courts of no State may execute the penal laws of another (see the Antelope (10 Wheat. 66, 123, 6 L. Ed. 268, 282) and *State of Wisconsin* v. *Pelican Ins. Co.*, 127 U.S. 265 32 L. Ed. 235 (1890)) would yield to the constitutional requirement that every State must give full faith and credit to the judgments and decrees of other States.

In summary, the thrust of the discussion at the zone II meeting was that the "state of impact" is well able to control mail-order companies through interstate cooperation and through broadened recognition of the full faith and credit clause.

Question 6. "The statement says that individual commissioners have issued warnings against dealing with unlicensed companies. We would appreciate copies of these statements for our hearing record."

Although the time available since receipt of your letter of June 2 has been insufficient to compile anything approaching an exhaustive collection of such warnings, illustrative examples thereof are enclosed in the form of letters or other releases issued by the insurance commissioners of New York, Ohio, and Oklahoma.

Question 7. "Do you have any additions to this exchange from the hearing record?

"Senator WILLIAMS. Thank you very much, Mr. Parker. We appreciate your appearing for the association.

"I just wanted to make an observation and ask one question.

"Earlier witnesses—I believe you were here—indicated that insurance commissioners and State insurance commissioners cannot reach the active test in the health service area where the program is not insurance, but health, service.

"Did you hear that?

"Mr. PARKER. Yes, I heard that.

"I was surprised because I think in most of the States now the service organizations do come under the regulation of the insurance department. They do in my State and we recently passed that act, too, by the way, only about 4 years ago.

"They put them under certain controls. There are certain things we cannot do, but they are regulated by my department.

"If Mr. Parker wishes to add individual comments on this or any other matter discussed at the hearing we would, of course, be happy to hear from him, too."

With respect to activities of health service plans, the statement which was made at the hearing of the Subcommittee on Frauds and Misrepresentations Affecting the Elderly on May 4, 1964, by T. Nelson Parker, commissioner of insurance of Virginia and former president of the National Association of Insurance Commissioners, that health service organizations do come under the supervision of the insurance department in most of the States is appropriate, factual, and is endorsed by the NAIC.

Of the "service" organizations, by far the largest are Blue Cross and Blue Shield, which are adequately supervised by State agencies. In most instances insurance departments are the regulatory bodies. In several States, other agencies perform this function.

In a very few States, there are proprietary or cooperative health care purchasing organizations. Generally, these too are supervised. In one State, where they are not, corrective measures are being studied by an interim committee of the State legislature.

I have been in contact with Mr. Lee Kuecklehan, president, National Association of Insurance Commissioners, and he has reviewed the information submitted herewith. He has authorized me to present this material to you on his behalf and on behalf of the NAIC. We trust that these answers are responsive to your additional questions.

Respectfully submitted.

WILLIAM R. MORRIS,
Director of Insurance, State of Ohio; Member, Executive Committee, National Association of Insurance Commissioners.

RULES GOVERNING ADVERTISEMENTS OF ACCIDENT AND SICKNESS INSURANCE

Whereas the insurance laws of this State and particularly (refer to specific sections of law) prohibit the transmission of information in the form of advertisements or otherwise in such a manner or of such substance that the insurance buying public may be deceived or misled thereby; and

Whereas said insurance laws establish only general standards by which advertisements in the field of individual, group, blanket, and franchise accident and sickness insurance should be prepared, disseminated, and regulated; and,

Whereas it is considered proper and desirable to implement and interpret the general statutory standards and to adopt proper procedures to expedite enforcement thereof by this office: Now, therefore, it is

Ordered, That the following standards for advertisements of such accident and sickness insurance as well as the administrative and enforcement procedures hereafter enumerated be and are hereby adopted as a formal and official rule (ruling) of this department:

SECTION 1. DEFINITIONS

A. An advertisement for the purpose of these rules shall include:

(1) Printed and published material and descriptive literature of an insurer used in newspapers, magazines, radio and TV scripts, billboards and similar displays; and

(2) Descriptive literature and sales aids of all kinds issued by an insurer for presentation to members of the public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and

(3) Prepared sales talks, presentations and material for use by agents and brokers, and representations made by agents and brokers in accordance therewith.

B. Policy for the purpose of these rules shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider, or endorsement which provides accident or sickness benefits, or medical, surgical or hospital expense benefits, whether on a cash indemnity, reimbursement, or service basis, except when issued in connection with another kind of insurance, other than life, and except disability and double indemnity benefits included in life insurance and annuity contracts.

C. Insurer for the purpose of these rules shall include any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds, fraternal benefit society, and any other legal entity engaged in the advertisement of a policy as herein defined.

D. These rules shall also apply to agents and brokers to the extent that they are responsible for the advertisement of any policy.

SECTION 2. ADVERTISEMENTS IN GENERAL

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.

SECTION 3. ADVERTISEMENTS OF BENEFITS PAYABLE, LOSSES COVERED OR PREMIUMS PAYABLE

A. *Deceptive words, phrases or illustrations.*—Words, phrases, or illustrations shall not be used in a manner which misleads or has the capacity and tendency to deceive as to the extent of any policy benefit payable, loss covered, or premium payable. An advertisement relating to any policy benefit payable, loss covered, or premium payable shall be sufficiently complete and clear as to avoid deception or the capacity and tendency to deceive.

Explanation:

(1) The words and phrases "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will pay your hospital and surgical bills," or "this policy will replace your income," or similar words and phrases shall not be used so as to exaggerate any benefit beyond the terms of the policy, but may be used only in such manner as fairly to describe such benefit.

(2) A policy covering only one disease or a list of specified diseases shall not be advertised so as to 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.

(3) The benefits of a policy which pays varying amounts for the same loss occurring under different conditions or which pays benefits only when a loss occurs under certain conditions shall not be advertised without disclosing the limited conditions under which the benefits referred to are provided by the policy.

(4) Phrases such as "this policy pays $1,800 for hospital room and board expenses" are incomplete without indicating the maximum daily benefit and the maximum time limit for hospital room and board expenses.

B. *Exceptions, reductions, and limitations.*—When an advertisement refers to any dollar amount, period of time for which any benefit is payable, cost of policy, or specific policy benefit or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive.

Explanation:

(1) The term "exception" shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

(2) The term "reduction" shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction clause not been used.

(3) The term "limitation" shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

(4) Waiting, elimination, probationary, or similar periods: When a policy contains a time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement covered by section 3B shall disclose the existence of such periods.

(5) Preexisting conditions: (*a*) An advertisement covered by section 3B shall disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy.

(*b*) When a policy does not cover losses traceable to preexisting conditions no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This limits the use of the phrase "no medical examination required" and phrases of similar import.

SECTION 4. NECESSITY FOR DISCLOSING POLICY PROVISIONS RELATING TO RENEWABILITY, CANCELABILITY, AND TERMINATION

An advertisement which refers to renewability, cancelability or termination of a policy, or which refers to a policy benefit, or which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy, shall disclose the provisions relating to renewability, cancelability, and termination and any modification 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.

SECTION 5. METHOD OF DISCLOSURE OF REQUIRED INFORMATION

All information required to be disclosed by these rules shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

SECTION 6. TESTIMONIALS

Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the

statements contained therein, and the advertisement including such statements is subject to all of the provisions of these rules.

SECTION 7. USE OF STATISTICS

An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact.

SECTION 8. INSPECTION OF POLICY

An offer in an advertisement of free inspection of a policy or offer of a premium refund is not a cure for misleading or deceptive statements contained in such advertisement.

SECTION 9. IDENTIFICATION OF PLAN OR NUMBER OF POLICIES

A. When a choice of the amount of benefits is referred to, an advertisement shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits.

B. When an advertisement refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

SECTION 10. DISPARAGING COMPARISONS AND STATEMENTS

An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or otherwise falsely disparage competitors, their policies, services, or business methods.

SECTION 11. JURISDICTIONAL LICENSING

A. An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

SECTION 12. IDENTITY OF INSURER

The identity of the insurer shall be made clear in all of its advertisements. An advertisement shall not use a trade name, service mark, slogan, symbol, or other device which has the capacity and tendency to mislead or deceive as to the true identity of the insurer.

SECTION 13. GROUP OR QUASI-GROUP IMPLICATIONS

An advertisement of a particular policy shall not state or imply that prospective policyholders become group or quasi-group members and as such enjoy special rates or underwriting privileges, unless such is the fact.

SECTION 14. INTRODUCTORY, INITIAL OR SPECIAL OFFERS

An advertisement shall not state or imply that a particular policy or combination of policies is an introductory, initial, or special offer and that the applicant will receive advantages by accepting the offer, unless such is the fact.

SECTION 15. APPROVAL OR ENDORSEMENT BY THIRD PARTIES

A. An advertisement shall not state or imply that an insurer or a policy has been approved or an insurer's financial condition has been examined and found to be satisfactory by a governmental agency, unless such is the fact.

B. An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by any indivilual, group of individuals, society, association, or other organization, unless such is the fact.

SECTION 16. SERVICE FACILITIES

An advertisement shall not contain untrue statements with respect to the time within which claims are paid or statements which imply that claim settlements will be liberal or generous beyond the terms of the policy.

SECTION 17. STATEMENTS ABOUT AN INSURER

An advertisement shall not contain statements which are untrue in fact or by implication misleading with respect to the insurer's assets, corporate structure, financial standing, age, or relative position in the insurance business.

SPECIAL ENFORCEMENT PROCEDURES FOR RULES GOVERNING THE ADVERTISEMENT OF ACCIDENT AND SICKNESS INSURANCE

(1) *Advertising file.*—Each insurer shall maintain at his home or principal office a complete file containing every printed, published, or prepared advertisement of individual policies and typical printed, published, or prepared advertisements of blanket, franchise, and group policies hereafter disseminated in this or any other State whether or not licensed in such other State, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by this department. All such advertisements shall be maintained in said file for a period of not less than 3 years.

(2) *Certificate of compliance.*—Each insurer required to file an annual statement which is now or which hereafter becomes subject to the provisions of this rule (ruling) must file with this department together with its annual statement, a certificate executed by an authorized officer of the insurer wherein it is stated that to the best of his knowledge, information, and belief the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions (of the insurance laws of this State as implemented and interpreted by this rule/ruling) (of this rule/ruling). It is requested that the chief executive officer of each such insurer to which this rule (ruling) is addressed acknowledge its receipt and indicate its intention to comply therewith.

Effective date of this rule (ruling) 90 days from date hereof.

Dated this ——— day of ————, 1955.

Signature————————————————.

Adopted by the National Association of Insurance Commissioners on December 1, 1955, and amended December 3, 1956.

REPORT OF THE SUBCOMMITTEE ON INTERPRETATION OF THE NAIC RULES GOVERNING ADVERTISEMENT OF ACCIDENT AND SICKNESS INSURANCE (A SUBCOMMITTEE OF THE ACCIDENT AND HEALTH COMMITTEE)

Shortly after the creation of this subcommittee by action of the NAIC at its December 1955 meeting in New York City, the chairman of the accident and health committee appointed the following members, the last named being designated as subcommittee chairman:

Commissioner Thomas Gillooly, of West Virginia.
Commissioner Cyril Sheehan, of Minnesota.
Commissioner Donald Knowlton, of New Hampshire.
Superintendent Leffert Holz, of New York.
Director Thomas R. Pansing, of Nebraska.

The subcommittee then appointed the following industry advisory group to assist in its work:

Valentine Howell, representing Life Insurance Association of America.
Jay C. Higdon, representing American Life Convention.
Berkeley Cox, representing Association of Casualty and Surety Companies.
Joseph J. McGee, Jr., representing Association of Insurance Advertisers.
Paul Watt, representing Health and Accident Underwriters Conference.
Charles D. Dougherty, representing Bureau of Health and Accident Underwriters.
J. W. Scherr, Jr., representing Life Insurers Conference.

Chase M. Smith, representing American Mutual Alliance.
Artemas C. Leslie, representing Blue Cross Commission.
Donald T. Diller, representing Blue Shield Commission.

Approximately 15 meetings of the subcommittee or working portions thereof have been held in New York City, Chicago, Washington, Cincinnati, and St. Louis. Superintendent Holz has at all times been represented by Julius Wikler, his first deputy superintendent.

In accordance with its instructions, the subcommittee has prepared and appends hereto a guide which is intended to be interpretive of the NAIC rules governing advertisement of accident and sickness insurance adopted by the NAIC at its aforementioned meeting in December 1955. (See NAIC proceedings, midwinter meeting, New York City, 1955, report of accident and health committee.)

It is the belief of the subcommittee that this interpretive guide should be regarded only as the opinion of the foregoing members of the subcommittee and its industry advisory group. It is thought by them to be a reasonable approach for use by State commissioners in administering said rules and by company advertisers in preparing advertisements within the provisions of said rules. It is not contemplated that the guide in all of its detail shall become the official act or recommendation of the accident and health committee or of the NAIC or that it will be adopted by any State. Instead, it should be considered to be just what its name implies, a guide, and no more, entirely without force of law, for reference only in such situations as it may be found to be useful. Furthermore, it is expected that frequent changes in the guide will be recommended by this subcommittee from time to time as new and changed facts and problems appear in this field of advertising.

Another function of this subcommittee is to consider and recommend from time to time changes in the aforementioned rules themselves, as the need for such changes becomes apparent. During the past 6 months, the subcommittee has spent its time and effort on preparation of the interpretative guide and has not considered suggested rule changes. During this period, however, suggestions have been received pertaining to proposed rule changes, and it should be the next order of subcommittee business to consider the same. Those rules which have been most widely controverted and should soon receive subcommittee attention are—

Rule 1C, with respect to a different definition and treatment of agents and brokers;

Rule 4, with respect to the words "or for other reasons," etc.; and

Rule 11B, particularly with respect to its proposed deletion.

There are, and will be, others, of course.

As previously authorized, in response to specific request of the Federal Trade Commission, the subcommittee appeared at two public hearings (on February 8 and April 30, 1956) called by the Commission as part of its fair trade practice conference procedure. At the specific request of the chairman of that conference, the aforementioned rules were placed in the record at the first hearing, after which Commission personnel prepared their own proposed rules, which were then made the subject of the second hearing.

In accordance with all of the foregoing report, the subcommittee unanimously recommends, as follows:

I. That the appended interpretative guide to the NAIC rules governing advertisement of accident and sickness insurance be received, that it not be made a part of the official proceedings of this meeting of the NAIC and that the assistant secretary of the association be directed to reproduce said guide so that one or more copies may be mailed to each State commissioner and so that additional copies may be available as needed.

II. That the subcommittee, during the ensuing 6 months, receive and consider suggested changes of the aforementioned NAIC rules, giving first attention to the three proposed changes specifically mentioned above.

III. That the subcommittee, during the enusing 6 months, receive and consider suggested changes in the interpretive guide.

IV. That the subcommittee report its activities to the December 1956 meeting of this association.

V. That this report be approved.

Respectfully submitted.

DONALD KNOWLTON.
LEFFERT HOLZ.
THOMAS GILLOOLY.
CYRIL SHEEHAN.
THOMAS R. PANSING, *Chairman.*

Interpretive Guide for the NAIC Rules Governing Advertisement of Accident and Sickness Insurance

BASIC PRINCIPLES OF INTERPRETATION

The proper promotion, sale, and expansion of accident and sickness insurance are in the public interest, and the rules are to be construed in such a manner as not to restrict, inhibit, or retard such promotion, sale, and expansion.

In applying the rules, it must be recognized that advertising plays an essential part in promoting a broader distribution of accident and sickness insurance. Advertising necessarily seeks to serve this purpose in various ways. Some advertisements are the direct or principal sales inducement and are designed to invite offers to contract. In other advertisements, the function is to describe coverage broadly for the purpose of inviting inquiry for further information. Still other advertisements are solely for the purpose of promoting the reader's interest in the concept of accident and sickness insurance or of promoting the insurer sponsoring the advertisement. These differences should be given recognition through interpretation of the rules. Further, it should be recognized that exceptions, reductions, and limitations have an important role in defining coverage for the purpose of keeping insurance costs within reasonable bounds.

Therefore, when applying the rules to a specific advertisement, it will be necessary to take into consideration the detail, character, purpose, use, and entire content of the advertisement.

SPECIFIC PRINCIPLES OF INTERPRETATION

The rules apply to group as well as individual accident and sickness insurance. Because the two differ widely in many respects, it follows that one interpretation will not always suffice for both. When that is the case, a specific interpretation for group is set forth. Some of the distinctions between individual and group that should be taken into account in applying the rules are:

1. Frequently the prospective group policyholder is thoroughly conversant with insurance or employs competent insurance advisers.
2. Group plans are often the result of collective bargaining whereunder the plan must continue in existence for a specified period of time even though the insurance carrier may be changed.
3. Many group contracts are tailormade to fit the policyholder's particular situation and are the result of extensive negotiations.
4. Group insurance generally contemplates that all or part of the premium is to be paid by the group policyholder.
5. The insurance provided by a group plan may be underwritten by several different insurers.
6. Much group insurance material is prepared and published after the contract is written.
7. Some States have statutory forms of group coverage.

SECTION 1. DEFINITIONS

A. An advertisement for the purpose of these rules shall include—

(1) Printed and published material and descriptive literature of an insurer used in newspapers, magazines, radio, and TV scripts, billboards, and similar displays;

(2) Descriptive literature and sales aids of all kinds issued by an insurer for presentation to members of the public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and

(3) Prepared sales talks, presentations, and material for use by agents and brokers, and representations made by agents and brokers in accordance therewith.

B. Policy for the purpose of these rules shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides accident or sickness benefits or medical, surgical, or hospital expense benefits, whether on a cash indemnity, reimbursement, or service basis, except when issued in connection with another kind of insurance other than life, and except disability and double-indemnity benefits included in life insurance and annuity contracts.

C. Insurer for the purpose of these rules shall include any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds, fraternal benefit society, and any other legal entity engaged in the advertisement of a policy as herein defined.

D. These rules shall also apply to agents and brokers to the extent that they are responsible for the advertisement of any policy.

Interpretation of section 1A (1)

Advertisements for the sole purpose of obtaining employees, agents, agencies, or brokers are among those not to be considered within the definition of an "advertisement."

Interpretation of section 1A (2)

The definition of the word "advertisement" is intended to include material used in the solicitation of renewals and reinstatements except for communications or notices which mention the cost of the insurance but do not describe benefits. It does not include material in house organs of insurers, communications within an insurer's own organization not intended for dissemination to the public, individual communications of a personal nature, nor correspondence between a prospective group policyholder and an insurer in the course of negotiating a group contract.

With respect to existing groups, reprints of group booklets after the effective date of the rules shall be considered within the definition of an "advertisement," however, until January 1, 1958, insurance companies shall not be prohibited from distributing already printed group booklets.

A general announcement from a group policyholder to eligible individuals that a contract has been written is not intended to be an advertisement within the meaning of the rules if it clearly indicates that it is preliminary to a booklet.

Interpretation of section 1A (3)

Materials to be used solely for the training and education of its employees, agents or brokers are not within the purview of the rules.

Interpretation of section 1B

The language in section 1B "except disability and double indemnity benefits included in life insurance and annuity contracts" shall be interpreted to mean "except disability and double indemnity benefits included in life insurance endowment or annuity contracts or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (*a*) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (*b*) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract."

Interpretation of section 1C

An insurer is not responsible for an advertisement which is not under its direct or indirect control.

SECTION 2. ADVERTISEMENTS IN GENERAL

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.

Interpretation of section 2

The purpose of the first sentence of section 2 is twofold. First, it states the general purpose of the rules by prohibiting advertisements which are not only false but which may mislead either in fact or by implication. It does for instance recognize that advertisements may be misleading even though literally true and capable of proof. Secondly, it establishes a broad principle designed to prohibit untruthful and misleading advertisements in addition to those principles covered by specific sections of the rules. To that extent it may be considered a "catchall" rule.

The second sentence of this section is intended to prohibit the use of incomplete statements and words or phrases which, because of the reader's unfamiliarity with insurance terminology, have the tendency and capacity to mislead or deceive. It places no prohibition on the use of any particular words or phrases but does require that all terminology used in an advertisement, whether it be insurance terminology or otherwise, be sufficiently clear so to avoid being misleading. In interpreting this particular portion of section 2, it must be recognized that insurance terminology is often essential to properly explain the coverage being advertised.

As a general principle, words or phrases which are commonly understood by the public with respect to insurance, for example, such words or phrases as premiums, policies, contracts, reinstatement, lapse, grace period, capital, assets, investments, legal reserve, insurer, insured, policyholders, insurance company and insurance usually need not be further clarified in the context of the advertisement. However, certain words or phrases may, unless adequately clarified in the context of the advertisement, mislead those who are not familiar with insurance terminology.

SECTION 3. ADVERTISEMENTS OF BENEFITS PAYABLE, LOSSES COVERED, OR PREMIUMS PAYABLE

A. Deceptive words, phrases, or illustrations

Words, phrases, or illustrations shall not be used in a manner which misleads or has the capacity and tendency to deceive as to the extent of any policy benefit payable, loss covered, or premium payable. An advertisement relating to any policy benefit payable, loss covered, or premium payable shall be sufficiently complete and clear as to avoid deception or the capacity and tendency to deceive.

Explanation:

(1) The words and phrases "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will pay your hospital and surgical bills" or "this policy will replace your income," or similar words and phrases shall not be used so as to exaggerate any benefit beyond the terms of the policy, but may be used only in such manner as fairly to describe such benefit.

(2) A policy covering only one disease or a list of specified diseases shall not be advertised so as to 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.

(3) The benefits of a policy which pays varying amounts for the same loss occurring under different conditions, or which pays benefits only when a loss occurs under certain conditions, shall not be advertised without disclosing the limited conditions under which the benefits referred to are provided by the policy.

(4) Phrases such as, "this policy pays $1,800 for hospital room and board expenses" are incomplete without indicating the maximum daily benefit and the maximum time limit for hospital room and board expenses.

B. Exceptions, reductions, and limitations

When an advertisement refers to any dollar amount, period of time for which any benefit is payable, cost of policy, or specific policy benefit or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive.

Explanation:

(1) The term "exception" shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

(2) The term "reduction" shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction clause not been used.

(3) The term "limitation" shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

(4) Waiting, elimination, probationary, or similar periods: When a policy contains a time period between the effective date of the policy and the effective date of coverage under the policy or a time period the date a loss occurs and the date benefits begins to accrue for such a loss, an advertisement covered by section 3B shall disclose the existence of such periods.

(5) Preexisting conditions: (*a*) An advertisement covered by section 3B shall disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy.

(*b*) When a policy does not cover losses traceable to preexisting conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This limits the use of the phrase "no medical examination required" and phrases of similar import.

Interpretation of section 3 generally

To interpret section 3 properly, it is necessary, first, to distinguish between sections 3A and 3B. Generally, the purpose of section 3A is to prevent an insurer from exaggerating the extent of policy benefits or minimizing cost by using phraseology which either overstates benefits or is so incomplete as to leave an exaggerated idea of benefits in the mind of the reader. The first sentence of the section and explanations 1 and 2 prohibit and explain exaggeration by overstatement. The second sentence of the section and explanations 3 and 4 prohibit and explain exaggeration by incompleteness.

Section 3B extends this principle of "no exaggeration." In essence it states that in certain types of advertisements the only way that exaggeration of benefits can be avoided is to set forth in the same advertisements certain of the limitations, exceptions, and reductions affecting the benefits described.

Section 3A applies to any advertisement which discusses benefits. Section 3B applies only to an advertisement which discusses benefits to the extent of mentioning the dollar amount or time limit of the benefits or cost of the policy or benefits thereunder.

Because the basic purpose of both rules is the same, to prevent exaggeration, they must necessarily overlap at times. For example: In advertising a policy which contains an aggregate benefit limit, it would be improper to use alone the phrase "no limit on the number of claims" because the second sentence of section 3A requires completion of the statement in some manner like "no limit on the number of claims until the aggregate amount x dollars has been paid." If elsewhere the advertisement contains a discussion of dollar amount or time limit of benefits or cost of the policy or its benefits, section 3B requires that the aggregate amount be set forth because it is an important "limitation." Therefore, in this example, the aggregate amount should be set out because both sections 3A and 3B require it.

The distinction between sections 3A and 3B can best be explained as follows: Section 3A is only concerned with phraseology of benefit descriptions in an advertisement. Section 3B is not primarily concerned with phraseology but, in advertisements to which it applies, in having certain limitations, exceptions and reductons set forth. It is simply coincidental that to meet the phraseology requirements of section 3A it may sometimes be necessary to describe a limitation, exception, or reduction.

Interpretation of section 3A, specifically

In interpreting section 3A the following suggestions should be observed:

1. Language which states or implies that a certain age group or groups are eligible for coverage when such is not the fact is unacceptable.
2. Language which states or implies that each member under a "family" contract is covered as to the maximum benefits advertised when such is not the fact is unacceptable.
3. Advertisements which indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of people are unacceptable if in the issuance of policies such distinctions are not maintained.
4. The importance of diseases rarely or never found in the class of persons to whom the policy is offered shall not be exaggerated in an advertisement.
5. Section 3A3 applies only to "limited benefit" type policies, the term to be given the connotation it usually receives in the industry.
6. A limited benefit-type policy should be identified as such when advertised by disclosure of its limited character.

For example, automobile, air, and railroad travel policy advertisements should disclose that they are limited to accidents resulting from automobile, air, or railroad travel, as the caes may be, as well as the limited manner in which the accident must occur, including any unusual conditions.

7. Examples of what benefits may be paid under a policy shall not disclose only maximum benefits unless such maximum benefits are paid for losses from common and probable illness rather than exceptional or rare illnesses.
8. When a range of hospital room rate benefits is set forth in an advertisement, it must be made clear that the insured will receive only the room rate benefit written or printed in the policy selected. Language which implies that the insured may select his room rate benefit at the time of hospitalization is unacceptable.

9. Language which implies that the amount of benefits payable under a loss-of-time policy may be increased at time of disability according to the needs of the insured, is unacceptable.

10. The term "confining sickness" is an abbreviated expression and in the case of either lifetime benefits or benefits for shorter periods the term must be explained in the advertisement. An example of an acceptable explanation would be: "Benefits are payable for total disability due to confining sickness only so long as the insured is necessarily confined indoors." Captions such as "Lifetime Sickness Benefits" or "Five-Year Sickness Benefits" are incomplete if such benefits are subject to confinement requirements. When sickness benefits are subject to confinement requirements, captions such as "Lifetime Confining Sickness Benefits" or "Five-Year Confining Sickness Benefits" would be acceptable.

11. The following are specific examples of the type of advertising prohibited or permitted by section 3A:

Advertisements shall not state that the insurer—

"pays hospital, surgical, etc. bills,"
"pays dollars to offset the cost of medical care,"
"safeguards your standard of living,"
"pays full coverage" or "pays complete coverage,"
"pays for financial needs,"
"provides for replacement of your lost paycheck,"

unless the statement in each instance is literally true. Where appropriate such or similar works or phrases may properly be used if preceded by the words "help," "aid," "assist" or similar words or phrases.

12. Advertisements which state that the premiums will not be changed in the future are not acceptable, unless such is the fact.

Interpretation of section 3B, specifically

That part of section 3B which reads as follows: "When an advertisement refers to any dollar amount, period of time for which any benefit is payable, cost of policy, or specific policy benefit or the loss for which such benefit is payable, * * *." attempts to define the type of advertisement which must meet the requirements set forth in the remaining language of the section. The words "dollar amount" appearing above should be interpreted as meaning "dollar amount of benefits."

It is possible to have an advertisement which does not specifically mention dollar, time, or cost, but accomplishes the same objective by indirection. For example, if there were a hospital and surgical expense policy which paid all incidental hospital expenses, it might be advertised as follows: "When you are covered under our hospital and surgical expense policy, we pay all your incidental hospital expenses." Or an advertisement of a major medical expense policy may truthfully promise to pay 75 percent of hospital, medical, and surgical expenses in excess of the deductible. In both of these examples, language is employed which is sufficiently specific to indirectly disclose to the reader the dollar amount to which he may become entitled. The language of the rule mentioned above, to wit: "Specific policy benefit or the loss for which such benefit is payable" was inserted to describe this type of advertisement.

As was noted in the "Basic Principles of Interpretation" advertisements generally fall within three categories. To properly apply the philosophy expressed in the first paragraph of the "Basic Principles," the meaning of section 3B must be examined in the light of each category. The first category of advertisements includes those which are the direct or principal sales inducements and are designed to invite offers to contract, i.e., clearly attempt to persuade the reader or listener to purchase the policy or policies advertised. When such an advertisement mentions dollar amount or time limit of benefits or cost of policy or policy benefits, it is always subject to the limitations imposed by the mandatory portion of section 3B.

The second category of advertisements includes those designed to attract the reader's interest in the policy or policies advertised so that he will inquire for further details and information. This type of advertisement usually describes benefits broadly. It may make some mention of dollar amount, time limits, or cost. Such mention, however, does not in itself means that the requirements of section 3B are applicable if the advertisement clearly falls within the category of an invitation to inquire.

To illustrate the foregoing: A brief television commercial or a direct mail card may state, "X company invites you to inquire for full information about

their $14 a day hospital expense policy." This advertisement is obviously not in the first category, an invitation to contract, but rather in the second category, an invitation to inquire. The viewer or reader could not reasonably decide to purchase the policy described on the basis of the information given even though it does mention a dollar amount.

But suppose the advertisement states, "X company invites you to inquire for full information about its $14 a day hospital expense policy which will cost you only 4 cents a day." Unlike the first example, it is more than a mere invitation to inquire for further details and should fall within the scope of section 3B. The distinction between the two advertisements is plain, if it is borne in mind, in the examples given that at least two kinds of information are needed by a prospective purchaser to determine whether he wishes to buy. He needs to know (1) what he will get, and (2) what it will cost. If he only knows what he will get without knowing the cost or if he knows only what he must pay without knowing what he will get, his only reasonable course is to seek further information. The principle followed in the above examples is that if those advertisements which fall within the category of an invitation to inquire withhold some facts without which no one could reasonably decide to buy the policies advertised, such advertisements are not subject to the limitations imposed by section 3B. It should be recognized that there is no single conclusive test and that each advertisement is weighed individually.

It is also true that if the description of dollar, time, or cost is merely for the purpose of identifying the policy, section 3B should not apply. Conversely, if the mention of dollar, time, or cost is for the purpose of doing more than identifying the policy, section 3B may apply.

Thus, it can be seen that many advertisements falling within the "invitation-to-inquire" category are not subject to the requirements of section 3B, but as has been shown, there will be times when their language is such as to make compliance necessary.

The third category of advertisements includes those of an institutional type. Rarely is it likely that dollar amounts, time limits, or cost will be mentioned in this class. Section 3B, therefore, has little or no application to advertisements in this category.

We turn now to consideration of the mandatory portion of section 3B which reads as follows:

"* * * it shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity and tendency to mislead or deceive."

Where section 3B applies, it is clear that it is not necessary to disclose all exceptions, reductions, and limitations. The following are examples of exceptions, reductions, and limitations that generally do affect the basic provisions and "without which the advertisement would have the capacity and tendency to mislead or deceive." Also included are examples of those that generally are not of sufficient significance to affect the basic provisions or to mislead if omitted. The lists are not intended to be complete and the advertiser should use the lists as a guide in determining the character of exceptions, reductions, and limitations that do not appear.

Generally do affect the basic provisions and without which the advertisement would have the capacity and tendency to mislead or deceive.

1. War or act of war.
2. While in armed services.
3. Territorial restriction on coverage within the United States and Canada.
4. Complete aviation exclusion.
5. Self-inflicted injury.
6. Injury inflicted by another person.
7. Preexisting sickness or disease.
8. Exclusion or reduction for loss due to preexisting bodily infirmities.
9. Exclusion or reduction for loss due to specific diseases, classes of diseases, or types of injuries.
10. Confinement restrictions in disability policies such as house confinement, bed confinement, and confinement to the premises.
11. Waiting periods.
12. Reduction in benefits because of age.
13. Any reduction in benefit during a period of disability.
14. Workmen's compensation or employers' liability law exclusion.
15. Occupational exclusion.

16. Violation of law.
17. Automatic benefit in lieu of another benefit.
18. Confinement in Government hospital.
19. Maternity.
20. Miscarriage in accident and sickness policy.
21. Restrictions relating to organs not common to both sexes.
22. Restrictions on number of hospital hours before benefit accrues.
23. Insanity, mental diseases or disorders, or nervous disorder.
24. Dental treament, surgery, or procedures.
25. Cosmetic surgery.
26. While intoxicated or under the influence of narcotics or other language not in conformity with the uniform policy provision law.
27. Unemployed persons.
28. Retired persons.
29. While handling explosives or chemical compounds.
30. While or as a result of participating in speed contests.
31. While or as a result of riding a motorcycle or motorcycle attachment.
32. While or as a result of participating in professional athletics.
33. While or as a result of participating in certain specified sports.
34. While or as a result of serving as a volunteer fireman or in other hazardous occupations.
35. Riot or while participating in a riot.
36. Ptomaine poisoning.
37. Gas or poisonous vapor.
38. Sunstroke or heat prostration.
39. Freezing.
40. Poison ivy or fungus infection.
41. Requirement of permanent disability.

Generally do not affect the basic provisions and without which the advertisement would not have the capacity and tendency to mislead or deceive.

1. Suicide, sane or insane.
2. Attempted suicide, sane or insane.
3. Intentional self-inflicted injury.
4. Territorial restriction with no limitation of coverage in the United States and Canada.
5. Aviation exclusion, except as passenger on commercial airlines.
6. Felony or illegal occupation.
7. Time limitation on death, dismemberment, or commencement of disability following an accident.
8. All statutory standard and policy provisions, both mandatory and optional.
9. Requirement for regular care by a physician.
10. Definition of total disability.
11. Definition of partial disability.
12. Definition of hospital.
13. Definition of specific total loss.
14. Definition of injury.
15. Definition of physician or surgeon.
16. Definition of nurse.
17. Definition of recurrent disability.
18. Definition of commercial air travel.
19. Definition classifying hernia as a sickness.
20. Rest cures.
21. Diagnoses.
22. Prosthetics.
23. Cosmetic surgery, except as a result of accident occurring while policy is in force.
24. Dental treatment, surgery, or procedures, except for injury to sound natural teeth occurring while policy is in force.
25. Bacterial infection, except pyogenic infection occurring through cut or wound caused by injury.
26. Eye examination for fitting of glasses or hearing aids.
27. Exclusion of sickness or disease in a policy providing only accident coverage.
28. Exclusion for miscarriage in policy providing only accident coverage.

SECTION 4. NECESSITY FOR DISCLOSING POLICY PROVISIONS RELATING TO RENEWABILITY, CANCELABILITY, AND TERMINATION

An advertisement which refers to renewability, cancelability, or termination of a policy, or which refers to a policy benefit, or which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy, shall disclose the provisions relating to renewability, cancelability, and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in manner which shall not minimize or render obscure the qualifying conditions.

Interpretation of section 4

Section 4 is divided into two parts. The first part defines the type of advertisement that is subject to the restrictions imposed upon such advertisement by the second part.

The first part of section 4 reads as follows:

"An advertisement which refers to renewability, cancelability, or termination of a policy, or which refers to a policy benefit, or which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy * * *."

Three distinct categories of advertisements are described:

In the first category is that type of advertisement "which refers to renewability, cancelability, or termination of a policy." This language was inserted in the section to prevent the advertisement of a noncancelable or guaranteed renewable insurance policy in such a manner as to overstate the noncancelable or guaranteed renewable feature. For example, suppose a noncancelable and guaranteed renewable to age 65, at a level premium, loss-of-time policy was advertised briefly in the following manner: "X company sells a noncancelable loss-of-time benefits policy." In this simple advertisement the insurer has chosen to discuss renewability or as the rule puts it "refers to renewability", etc. It is, therefore, bound by the provisions of section 4 and the language of its advertisement would have to read something like: "X company sells a noncancelable and guaranteed renewable to age 65 loss-of-time benefits policy." Statements like "This policy safeguards your renewal," or "Yours for as long as you want it" are further examples of advertisements which refer to renewability so as to make them subject to the limitation imposed by section 4. It is important to note that the restriction applies only to advertisements of specific policies.

In the second category is that type of advertisement "which refers to a policy benefit." In determining what is meant by the phrase "refers to a policy benefit," we must keep in mind the "Basic Principles of Interpretation." It will be recalled that these principles divide advertisements into three classes: "Offers to contract," "invitations to inquire" and "institutional advertisements."

"Offers to contract" invariably describe benefits in considerable detail because their purpose is to convince the reader that he should purchase the policy described. This type of advertisement is always subject to the requirements of section 4.

"Invitations to inquire" are designed to attract the reader's interest in the policy so that he will inquire as to further details and information. Often these are brief advertisements used in television and radio commercials, precall letters, newspapers, or magazines. The limitations imposed by section 4 should apply to this type of advertisement to the same extent that the limitations imposed by section 3B were found to apply to them. In other words, the language of the rule "refers to a policy benefit" should be interpreted to mean that an "invitation to inquire" which discusses dollar, time, or cost, extensively, is subject to the limitations imposed by section 4. If, however, the mention of dollar, time, or cost is such that the advertisement withholds some facts without which no one could reasonably decide to buy the policies advertised, the advertisement is not subject to the limitations imposed by section 4. This is an application to section 4 of the principle established in the interpretation of section 3B and recited on page 9 of this guide.

The third class outlined in the "Basic Principles of Interpretation" is the institutional type advertisement. It is unlikely that this type of advertisement will ever be subject to section 4 unless it "refers to renewability," etc., of a specific policy. As was discussed in an earlier paragraph, it should be remembered that every advertisement, regardless of its class, is always subject

to section 4 if it refers "to renewability, cancelability, or termination of a policy."

In the third category is that type of advertisement "which states or illustrates time or age in connection with eligibility of applicants or continuation of the policy."

There are advertisements which do not "refer to renawability," etc., nor "refer to a policy benefit," but nevertheless are subject to section 4.

These are advertisements which imply permanency by a discussion of age. For example an advertisement of a cancelable policy may say: "Coverage—ages 18 to 70," or "Does not terminate at any specific age—no reduction in benefits as you grow older." Although technically truthful when standing alone, the above type of statement in an advertisement may imply permanency unless properly qualified. It is not the intent of the rules, however, to bring all statements about eligibility age under section 4 but only those statements which have the tendency and capacity to mislead as to the premanence and continuability of the protection. Simple statements disclosing the company's underwriting policy with respect to age such as "Issued to people between the ages of 55 and 65," do not bring the advertisement under section 4. It is essential for the advertiser to use words in describing the issue ages which cannot be construed to imply that the ages refer to renewability. One example has been given. Another approach would be to say something like, "For sale to persons between 18 and 59 years of age."

This completes a determination of the type of advertisement subject to section 4. The remainder of section 4 relates to compliance and reads as follows: "* * * shall disclose the provisions relating to renewability, cancelability, and termination and any modification 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."

The word "provisions" used above does not contemplate that the policy language must be used. Rather, the rule requires a summary of the pertinent information with respect to renewability, etc. This word was used merely to distinguish it from the word "conditions" used later in the paragraph.

In applying section 4, the advertiser of a cancelable or optional-renewal policy is concerned only with the requirement that a summary of policy renewal provisions be set forth and is not concerned with that part of the rule which deals with "qualifying conditions." Advertisements of cancelable policies that come under section 4 must state that the contract in question is cancelable or renewal at the option of the company, as the case may be. For example, a policy which is cancelable should be advertised in a manner similar to: "This policy can be canceled by the company at any time." Policies which are renewable at the company's option should be advertised in a manner similar to: "Renewable at the option of the company," or "The company has the right to refuse renewal of this policy," or "The acceptance of a renewal premium is optional with the company."

With respect to the noncancelable or guaranteed renewable type policy, the rule requires two things: first that a summary of the policy provisions with respect to renewability be set forth and, second, that anything that modifies the permanent character of the policy be set forth. The disclosure of provisions relating to renewability, etc., will require the use of language such as "noncancelable," "guaranteed renewable," "noncancelable and guaranteed renewable," or "renewable at the option of the insured."

In addition to the requirement for disclosure of "provisions relating to renewability," etc., the rule requires a statement of the qualifying conditions which constitute limitations on the permanent nature of the coverage. These customarily fall into three categories: (1) Age limits, (2) reservation of a right to change premiums, and (3) the establishment of aggregate limits. For example, "noncancelable and guaranteed renewable" does not fulfill the requirement of section 4. If the policy contains a terminal insurance age of 65 a proper statement would be "Noncancelable and guaranteed renewable to age 65." An advertisement is not required to distinguish among terminations (*a*) on the insured's birthday, (*b*) on the policy anniversary nearest or following such date, (*c*) on the premium date following such date, or (*d*) any similar method of defining the termination date. If a right to change premiums is reserved, the statement must be amplified to language similar to "Guaranteed renewable to age 65 but the company reserves the right to change premium rates on a class basis." If the contract contains an aggregate limit after which no further benefits are payable, the above statement must be amplified with the phrase,

"subject to maximum dollar amounts payable by the company as set out in the policy," or similar language. It should be borne in mind that one policy may have one or more of the three basic limitations. The advertisement must show those which the policy contains.

In addition to the above basic requirements, the rule necessitates a disclosure of "* * * any modification of benefits, losses covered, or premiums because of age or for other reasons * * *." Because of the context of the section as a whole, this must be interpreted to mean only "modification of benefits," etc. which detract from the permanent nature of the coverage being offered. In other words, the rule is not a repetition of section 3B which requires the setting forth of certain limitations, exceptions, and reductions when an advertisement describes benefits extensively. Rather, section 4, under certain circumstances, requires only the description of those limitations which directly affect the permanent nature of the policy. For example, a provision for modification of benefits or increase of premium on account of change of occupation does not affect the permanent nature of the policy and, therefore, is not required to be disclosed by section 4. Another example of a modification of benefits which does not affect the permanent nature of the coverage is a terminal reduction, i.e., a provision for the termination of benefit payments at or about the terminal age (65, for example).

On the other hand, provisions for reduction of benefits at stated ages, other than terminal reductions, would have to be set forth because such a reduction does affect the permanent nature of the coverage. For example, a policy may contain a provision which reduces benefits 50 percent after age 50 although it is renewable to age 65. Such a reduction would have to be set forth. Also a provision for the elimination of certain hazards at any specific ages or after the policy has been in force for a specified time affects the permanent nature of the coverage and would have to be set forth. In this same category is the policy which provides for a stepped-up premium periodically. This, too, affects the permanency of coverage and would have to be set forth.

The foregoing is related to the type of advertisements subject to section 4 and what must be disclosed. The remainder of this interpretation relates to how the qualifying conditions must be disclosed. The language of the section reads: "* * * in a manner which shall not minimize or render obscure the qualifying conditions."

The qualifying conditions should be set forth with the language describing renewability. For example, "noncancelable and guaranteed renewable to age 65." In this example "to age 65" is properly stated with the words "noncancelable and guaranteed renewable."

It should be mentioned that when section 4 requires that an advertisement state the terminal age of a permanent-type policy, the statement of the age limit in the advertisement does not of itself bring the advertisement under section 3B.

In an advertisement of a group plan, subject to section 4, it is not necessary to describe the terms of the policy concerning cancelability or nonrenewability but the certificate holder must be advised therein that during the continuance of the contract his benefits are contingent upon his continued membership in the group.

SECTION 5. METHOD OF DISCLOSURE OF REQUIRED INFORMATION

All information required to be disclosed by these rules shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading.

Interpretation of section 5

The purpose of this section is to assure that all information required to be disclosed by the rules will be disclosed under one of two alternative methods in such a manner that the arrangement of the material itself will not have the capacity and tendency to confuse or mislead.

The first alternative permits the disclosure of exceptions, limitations, reductions, and other restrictions either in the description of a specific benefit to which they relate or in a paragraph set out in close conjunction with the description of specific policy benefits. An example of incorporating a reduction in the descrip-

tion of a specific policy benefit follows: $200 per month will be paid during total disability, beginning with the first day of such disability for as long as 24 months. Benefits are reduced 50 percent for disability commencing after attainment of age 65.

An example of incorporating exceptions, limitations, reductions, and other restrictions in a paragraph set out in case conjunction with the description of specific policy benefits follows:

This plan will pay you:

Accident benefits:

$1,000 for accidental death.

$200 per month for total disability, beginning with the first day of such disability for as long as 5 years.

$100 per month for partial disability, beginning with the first day of such disability or immediately following total disability for as long as 6 months.

Sickness benefits:

$200 per month for total disability, beginning with the eighth day of such disability for as long as 2 years.

Hospital and surgical benefits:

$10 per day during hospital confinement from first day of such confinement for as long as 90 days.

$5 to $200 under comprehensive surgical schedule specifying the maximum payment for each operation listed. The maximum payment will vary depending upon the nature of your operation.

Total premium $———— per ————.

The benefits described do not cover injury or disease: (1) existing before the policy date; (2) caused by war; or (3) occurring or commencing while in the Armed Forces.

The acceptance of a renewal premium is optional with the company. Benefits payable are reduced 50 percent for disability commencing or loss occurring after attainment of age 65.

The second alternative would permit the disclosure of exceptions, limitations, reductions, and other restrictions in some portion of the advertisement which is not in close conjunction with the provisions describing specific policy benefits, provided they were properly captioned.

For example, assuming that the last two paragraphs of the preceding example were separated from the description of the specific policy benefits by other material so as not to be in close conjunction with the benefit descriptions, then such paragraphs would have to be appropriately captioned as follows:

LIMITATIONS

The benefits described do not cover injury or disease: (1) existing before the policy date; (2) caused by war; or (3) occurring or commencing while in the Armed Forces.

The acceptance of a renewal premium is optional with the company. Benefits payable are reduced 50 percent for disability commencing or loss occurring after attainment of age 65.

The particular caption used above need not be used. For example, instead of the caption "Limitations," you might use "Exceptions," "Exclusions," "Not Covered," "Restrictions," "Extent of Coverage," or any other caption or combination of captions which would serve as notice of the exceptions, limitations or reductions from policy coverage.

Because of the different types of advertising media used to sell and promote accident and sickness insurance and the tremendous number and variety of techniques employed in each media, it was not practical to establish minimum and maximum requirements with respect to the size and style of type. Therefore, the "equal prominence" test was not employed in the rule nor should it be applied in the interpretation of the rule.

In summary, the purpose of this rule is to make certain that the information required to be disclosed is presented clearly and in such a manner as to be readily noticed.

SECTION 6. TESTIMONIALS

Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the

statements contained therein, and the advertisement including such statements is subject to all of the provisions of these rules.

Interpretation of section 6

The purpose of this section is to establish certain requirements to be observed when using testimonials in advertisements. Considering the rule in its component parts: First, all testimonials must be genuine. They must not be fictitious. Under this rule, the manufacturing, unscrupulous editing or "doctoring up" of a testimonial is clearly prohibited as being false and misleading.

Next, the testimonial must represent the current opinion of the author. When a testimonial is submitted in good faith, setting forth appreciation for benefits and favorable treatment received from an insurer, it follows, as a natural corollary, that the use of such testimonial must be limited to those instances where the testimonial, no matter when written, is still representative of the current opinion of the author. In other words, at the time of publication, the author should still believe what he had originally stated. The purpose of this requirement is to eliminate, as misleading, the use of testimonials in those cases where it is reasonable to presume that the views expressed in the testimonial do not correctly reflect current opinion of the author. It is conceivable that the writer of a testimonial, for one reason or another, might change his mind and no longer entertain the views originally expressed. This does not mean, per se, that an insurer, in each instance, is required to check with the author each time his testimonial is used to ascertain that the views expressed have not altered; but an insurer may not use a testimonial when it has information indicating a substantial change of view on the part of the author. A testimonial should be checked before use in those instances when a change of views might be probable or reasonable to assume, particularly by virtue of the passage of a considerable period of time. In this connection an insurer should not use a testimonial for more than 2 years after the date it is originally given or following a prior confirmation without obtaining a confirmation from the author that the testimonial represents his then current opinion.

This section, furthermore, prohibits testimonials which do not correctly reflect the present practices of the insurer. In other words, a testimonial, even though recently written and otherwise usable under this section, cannot be used if its statements describe practices no longer followed by the insurer. Such a testimonial would clearly be misleading.

A further possible misuse of testimonials is prohibited under the third part of the section in which it is required that the testimonial must be applicable to the policy or benefit being advertised. This is intended to eliminate the using of a testimonial given in connection with one policy to advertise another policy where such use would be misleading. This, of course, does not apply to testimonials of a general nature in which the author expresses appreciation for courteous treatment received, the prompt payment of benefits, and so forth.

Finally this section states that the testimonial must be accurately reproduced. Any change or omission which distorts the plain meaning or intent of the testimonial as originally written is prohibited. However, a testimonial need not stand or fall in its entirety as originally written. Certainly if a testimonial should reveal information of a personal nature or contain a statement that is not absolutely correct insofar as company procedures or practices are concerned, an insurer may omit such matter from a testimonial and then use the residual matter in its advertising, provided, of course, that in so doing the original view is not distorted. Also, a portion or a segment of a testimonial can be used provided such use does not result in a meaning different from that when such excerpt appeared in context in the original testimonial. The basic purpose is to prohibit distortion of the original views expressed in the testimonials in such manner that their use would be misleading.

The purpose of the last sentence of the section is to place responsibility for the truthfulness and accuracy of the testimonial on the insurer, and to prevent an insurer from avoiding the other requirements of the rules by the exclusive use of testimonial advertising. For example, if a testimonial refers to the dollar amount of any benefit, period of time for which any benefit is payable, or the cost of any benefit or policy, it would fall within the scope of section 3B and other applicable sections of the rules in the same manner as any other advertisements. However, a mere recital of the amount a company had paid to a claimant over a designated period of time in connection with a specific claim would not in itself render the testimonial subject to section 3B.

When the amount of aggregate benefits which have been paid to a particular claimant are recited in a testimonial, the statement of this claim payment should

not have the capacity and tendency to mislead a reader as to the true nature of the insurance coverage for which the payment was made. For example, if the author of a testimonial owned a loss-of-time policy which had paid him $600 loss-of-time benefits for a 3-month disability, it might create the impression that the policy paid for hospital expenses if he said, "When I was in the hospital for 3 months, the company paid me $600."

SECTION 7. USE OF STATISTICS

An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact.

Interpretation of section 7

If the term "loss ratio" is quoted, it should be based on (a) premiums received and benefits paid or (b) premiums earned and losses incurred.

An advertisement representing the dollar amounts of claims paid must also indicate the period over which such claims have been paid.

SECTION 8. INSPECTION OF POLICY

An offer in an advertisement of free inspection of policy or offer of a premium refund is not a cure for misleading or deceptive statements contained in such advertisement.

Interpretation of section 8

No comment believed necessary.

SECTION 9. IDENTIFICATION OF PLAN OR NUMBER OF POLICIES

A. When a choice of the amount of benefits is referred to, an advertisement shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits.

B. When an advertisement refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

Interpretation of section 9

No comment believed necessary.

SECTION 10. DISPARAGING COMPARISONS AND STATEMENTS

An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or otherwise falsely disparage competitors, their policies, services, or business methods.

Interpretation of section 10

No comment believed necessary.

SECTION 11. JURISDICTIONAL LICENSING

A. An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

Interpretation of section 11

An advertisement which contains testimonials from persons who reside in a State in which the insurer is not licensed or which refers to claims of persons residing in States in which the insurer is not licensed implies licensing in those States and therefore is in violation of this section unless the advertisement otherwise states.

SECTION 12. IDENTITY OF INSURER

The identity of the insurer shall be made clear in all of its advertisements. An advertisement shall not use a trade name, service mark, slogan, symbol, or other device which has the capacity and tendency to mislead or deceive as to the true identity of the insurer.

Interpretation of section 12

This section prohibits the use of the name of an agency or "_____ underwriters" or "_____ plan" in type, size, and location so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

This section does not prohibit the use of the initials, the trade name, or a portion of the corporate name of the insurer unless such use has the capacity and tendency to mislead or deceive as to the true identity of the insurer, in which event the insurer should set forth its full name and its home or principal office, i.e., city and State.

This section prohibits an insurer from using an address so as to mislead or deceive as to its true identity or licensing status.

SECTION 13. GROUP OR QUASI-GROUP IMPLICATIONS

An advertisement of a particular policy shall not state or imply that prospective policyholders become group or quasi-group members and as such enjoy special rates or underwriting privileges, unless such is the fact.

Interpretation of section 13

This section prohibits the use of representations to any segment of individuals that a particular policy or coverage is available only to that, or similar segment of individuals as preferred risks, when actually such policy or coverage is available to eligible members of the public at large. There is no prohibition against advertising that a policy or coverage is available to only a particular segment of individuals such as professional men, businessmen, etc., as preferred risks when in actual underwriting practice such is the fact.

This section prohibits the solicitation of a particular class such as governmental employees by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when in fact the policy being advertised is sold only on an individual basis at regular rates.

SECTION 14. INTRODUCTORY, INITIAL, OR SPECIAL OFFERS

An advertisement shall not state or imply that a particular policy or combination of policies is an introductory, initial, or special offer and that the applicant will receive advantages by accepting the offer, unless such is the fact.

Interpretation of section 14

This section prohibits any statements or implication to the effect that only a specific number of policies will be sold or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.

SECTION 15. APPROVAL OR ENDORSEMENT BY THIRD PARTIES

A. An advertisement shall not state or imply that an insurer or a policy has been approved or an insurer's financial condition has been examined and found to be satisfactory by a governmental agency, unless such is the fact.

B. An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by an individual, group of individuals, society, association, or other organization, unless such is the fact.

Interpretation of section 15A

The word "approved" shall not be interpreted so as to permit an insurer to state or imply in an advertisement that a governmental agency has endorsed or recommended the insurer, its policies, or its financial condition.

This section does not prohibit an insurer from reproducing a portion of a filed report of examination of such insurer, conducted by one or more insurance departments, provided the portion reproduced is not taken out of context and thereby rendered untrue or misleading.

Interpretation of section 15B

This section requires current and valid endorsements. It would prohibit representations that a policy or plan of an insurer is a community health plan or program unless such policy or plan has been adopted by the particular community government for the residents of that community or has been so designated by law.

SECTION 16. SERVICE FACILITIES

An advertisement shall not contain untrue statements with respect to the time within which claims are paid or statements which imply that claim settlements will be liberal or generous beyond the terms of the policy.

Interpretation of section 16

No comment believed necessary.

SECTION 17. STATEMENTS ABOUT AN INSURER

An advertisement shall not contain statements which are untrue in fact or by implication misleading with respect to the insurer's assets, corporate structure, financial standing, age, or relative position in the insurance business.

Interpretation of section 17

Among other things, this section prohibits insurers which have been organized for only a brief period of time from advertising that they are "old" or from making similar untrue representations.

Illustrations of a "home office" building should not be used in a manner which will be misleading with respect to the actual size and magnitude of the insurer's business.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

ADVERTISING OF INSURANCE COMMITTEE REPORT

The meeting of the advertising of insurance committee was held, Tuesday, December 3, 1963, in the Turquoise Room of the Westward Ho Hotel at 2:30 p.m. A quorum was present.

It was announced that the scheduled meeting of the advertising advisory technicians subcommittee had been canceled pending instructions as to the scope of its assignment by the parent committee.

Comments were received from the industry and insurance department representatives with respect to the first three items on the agenda.

In connection with item 3 (revision of NAIC Rules governing advertisements of accident and sickness insurance), the industry was asked to comment on the desirability of having an all industry advisory committee work with the subcommittee.

The committee then met in executive session and considered the comments made at the open meeting with respect to an all industry advisory committee.

A report was made as to the action taken by this committee at its meeting on September 11, 1963, with respect to the Federal Trade Commission's "Proposed Guides for the Mail Order Insurance Industry." Copies of the letters exchanged between the chairman of this committee and the Chairman of the Federal Trade Commission are attached hereto.

The committee then instructed the advertising advisory technicians subcommittee to promptly initiate work with respect to agenda items 2 and 3.

With respect to agenda item 4, the executive secretary of the association was requested to continue procedures heretofore adopted in regard to surveillance of operations of the coordinated policy agreed upon by the Federal Trade Commission and the NAIC with regard to insurance advertising and sales practices. (Reference NAIC 1963 Proceedings, vol. II, p. 539.)

William F. Austin, chairman, South Carolina; James L. Bentley, vice chairman, Georgia; Joseph B. Loonam, Alaska; Stafford R. Grady, California; Robert A. Short, Delaware; Sidney I. Hashimoto, Hawaii; Richard G. Hershey, Illinois; Rufus D. Hayes, Louisiana; Walter D. Davis, Mississippi; Ralph F. Apodaca, New Mexico; Samuel C. Cantor, New York; Cyril E. King, Virgin Islands.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS,
Columbia, S.C., Sept. 18, 1963.

Hon. PAUL RAND DIXON,
Chairman, Federal Trade Commission,
Washington, D.C.

DEAR MR. DIXON: As chairman of the Advertising of Insurance Committee of the National Association of Insurance Commissioners, I am writing to you with regard to the request made in Mr. Beller's letter to me of July 22, 1963, that the committee give FTC staff the benefit of its views concerning the proposed FTC "Guides for the Mail Order Insurance Industry."

The NAIC Advertising of Insurance Committee met in New York City on September 11, 1963, to consider this matter, and this letter is written in accordance with action taken at that meeting.

You will recall that at the FTC–NAIC group meeting on January 14, 1963, the FTC requested that NAIC technicians be made available to meet with FTC staff with regard to the latter's proposed draft of the above-mentioned guides. This has been done. The NAIC staff group's report of its meeting with FTC staff on May 21, 1963, was received by this committee at the NAIC meeting in Seattle in June 1963. A copy of this report, which represents the views of this committee with reference to technical defects in the draft, is enclosed herewith, together with a memorandum prepared by Mr. Beller of the comments made by members of the NAIC staff group, including changes suggested by them to overcome the technical defects pointed out. At the present time this committee is not informed whether or not FTC intends to incorporate such suggested changes.

This committee is under the impression that the FTC does not wish any release made of its proposed guides and that it contemplates no hearing thereon prior to their promulgation. Under these unusual circumstances, this committee would not appear to be able to comply with the usual NAIC procedure of giving all interested parties opportunity to be heard before making final recommendations with respect to a proposal of such importance as that of the FTC guides. Under such restrictions the committee, which is composed of insurance commissioners of a small number of States, is not in position to supply further comments on the guides as drafted by FTC staff.

The committee plans to proceed with revision and expansion of the existing NAIC rules governing advertising of accident and sickness insurance so that all forms of insurance will be covered thereby. It will have been helped in this task by the initial work done by the NAIC staff group.

If the committee or the NAIC can be of further assistance to you in this regard, please let me know.

Sincerely yours,

WILLIAM F. AUSTIN,
Chief Insurance Commissioner.

FEDERAL TRADE COMMISSION,
Washington, D.C., October 2, 1963.

Hon. WILLIAM F. AUSTIN,
Chief Insurance Commissioner,
State of South Carolina,
Columbia, S.C.

DEAR MR. AUSTIN: Your letter of September 18, 1963, concerning the NAIC Advertising of Insurance Committee's consideration of our staff draft of proposed "Guides for the Mail Order Insurance Industry" has been received.

The NAIC staff group's report of its meeting with Federal Trade Commission staff members on May 21, 1963, which you say represents the views of your committee with reference to technical defects in the proposed guides, was not enclosed with your letter. We would appreciate your furnishing us with copy thereof.

You point out that your committee has not been informed as to whether the Commission intends to incorporate in the guides the changes suggested by the

NAIC staff group. The reason for this is that such determination will not be known until the Commission approves guides for the industry.

It is contemplated that guides for the mail order insurance industry will be issued by the Commission without prior release of proposed guides for hearing. This is in accord with our usual guide procedure and is considered appropriate under the circumstances.

The views of your committee as represented in the report to be furnished will, I am sure, be most helpful. You may be assured that they as well as the suggestions previously made by the NAIC staff group will receive thorough consideration by the Commission in taking final action in the matter of guides for the industry.

Your committee's cooperation in this matter is very much appreciated.

Sincerely yours,

PAUL RAND DIXON, *Chairman.*

FTC AND STATE INSURANCE BODIES DOVETAIL CURBS ON UNFAIR INTERSTATE INSURANCE PRACTICES

The Federal Trade Commission and the National Association of Insurance Commissioners have agreed on a coordinated policy with regard to insurance advertising and sales practices.

FTC Chairman Paul Rand Dixon and Lee I. Kueckelhan, president of the NAIC, made the following joint statement today:

"The Federal Trade Commission and State Insurance Commissioners have a common interest in curbing unfair or deceptive practices in the sale of mail-order insurance. In furtherance of this joint objective, the FTC and the National Association of Insurance Commissioners' Federal Liaison Committee have explored the means for developing a workable basis for cooperative action in handling complaints from the public or other sources."

As a result of this joint study, the FTC has put into effect the following procedure for processing complaints about insurance advertising:

Where, in its opinion, the FTC has jurisdiction over the subject matter of such a complaint received by it, the FTC will initiate such action in the matter as the facts warrant and will so notify the insurance commissioner of the State in which the company is domiciled, as well as the NAIC. In all other cases, the FTC will refer the complaint to the insurance commissioner of the State in which the company is domiciled, with copies to the insurance commissioner of the State in which the complainant resides and the NAIC.

By resolution adopted at its June 1963 meeting in Seattle, the NAIC has recommended that each State commissioner institute the following procedure with respect to complaints involving unfair or deceptive advertising of mail-order insurance:

Where an insurance commissioner receives such a complaint about an insurance company that is not licensed in his State, such complaint should be referred to the insurance commissioner of the State in which the company is domiciled. In any such case where the insurance commissioner of the State of domicile fails within a reasonable time to advise the referring commissioner that appropriate steps have been taken to eliminate recurrence of the use of any improper advertising involved in the case, the referring commissioner should transmit a copy of the material involved to the FTC and send an information copy to the NAIC.

ADVERTISING OF INSURANCE COMMITTEE REPORT (MEETING NO. 23)

A meeting of the advertising of insurance committee was held Tuesday, June 9, 1964, in the Iowa Room of the Leamington Hotel at 9 a.m. A quorum was declared present.

The report of subcommittee 01—advertising advisory technicians—was submitted by Seymour Goodman, New York, chairman of the subcommittee.

The report included a proposed set of rules to be considered by the full committee, with the indication that a model bill would be prepared by the subcommittee prior to the December meeting in Las Vegas.

No committee action was taken on the subcommittee report.

Mr. Fisher of the Oklahoma department moved that the full committee hold interim meetings prior to the December session, at which time a detailed study would be made with representatives of industry to determine the actual need for

considering such rules and proposed model bills as the subcommittee has proposed in its annual report. The motion was seconded and unanimously adopted.

Representatives of the California department submitted to the committee copies of an attorney's general opinion concerning the subject of advertising in California newspapers by insurance companiets unlicensed in the State of California. The opinion was distributed among represented departments.

Charles W. Gambrell, Chairman, South Carolina; James L. Bentley, Vice Chairman, Georgia; A. W. Lingle, Alaska; Stafford R. Grady, California; Robert A. Short, Delaware; Sidney I. Hashimoto, Hawaii; Richard G. Hershey, Illinois; Dudley A. Guglielmo, Louisiana; Walter D. Davis, Mississippi; Ralph F. Apodaca, New Mexico; Henry Root Stern, Jr., New York; Cyril E. King, Virgin Islands.

NEW YORK INSURANCE DEPARTMENT ISSUES WARNING: PHYSICIANS MUTUAL IS UNLICENSED INSURER

Superintendent of Insurance Henry Root Stern, Jr., today warned New York State residents of the risks involved in purchasing insurance offered by the Physicians Mutual Insurance Co. of Omaha.

The warning was issued as the State insurance department received inquiries arising from widespread mail-order solicitation of New York State residents by the company, which is not licensed to do business in this State.

The unauthorized company's mailed literature gives the misleading impression that its veterans' benefit health insurance policy is Government guaranteed and comparable to low-cost national service life (GI) insurance. Physicians Mutual also has been offering by mail a "40-plus" health insurance plan.

Mr. Stern pointed out that since the company is not licensed in New York, its financial condition, policy provisions, rates, and dealings with policyholders are not subject to examination by the insurance department. In addition, the department would not be able to assist policyholders in any dispute arising out of a claim under the policy. Thus, New Yorkers dealing with such unauthorized insurers lose the benefits provided for their protection by the laws of this State.

"Licensed companies must comply with specified financial requirements, must file annual reports of their financial condition, and are subject to thorough examination by the department concerning all phases of their operations, including claims handling," a department statement points out. "The department passes upon premium rates and provisions of many types of insurance policies" of licensed companies.

Policyholders frequently have difficulties in obtaining satisfactory settlements of claims against unlicensed insurers. In the case of licensed insurers, State law empowers the insurance department to see to their fair treatment of policyholders and settlement of claims in accordance with contract terms.

A similar warning against dealing with Physicians Mutual has been issued to New Jersey residents by Charles R. Howell, New Jersey commissioner of banking and insurance.

INSURANCE DEPARTMENT WARNS PUBLIC AGAINST TIME LIFE OF SAN ANTONIO

Superintendent of Insurance Henry Root Stern, Jr., today cautioned New York State residents against the risks involved in purchasing insurance from companies not authorized to do business in this State.

This warning was issued as a result of the continued advertising in this State, via newspapers, radio stations, and magazines by Time Life Insurance Co. of San Antonio, Tex., an unauthorized insurer. That company has been soliciting mail orders from New York residents for an accident and hospital policy offering benefits of $1,000 per month for hospitalization resulting from accidental injury.

Mr. Stern pointed out that since the company is not licensed in New York, its financial condition, policy provisions, rates, and dealings with policyholders are not subject to examination by the insurance department. In addition, the department would not be able to assist policyholders in any dispute arising out of a claim under the policy. Thus, New Yorkers dealing with such unauthorized insurers lose the benefits provided for their protection by the laws of this State.

"Licensed companies must comply with specified financial requirements, must file annual reports of their financial condition, and are subject to thorough ex-

amination by the department concerning all phases of their operations, including claims handling," a department statement points out. "The department passes upon premium rates and provisions of many types of insurance policies" of licensed companies.

Policyholders frequently have difficulties in obtaining satisfactory settlements of claims against unlicensed insurers. In the case of licensed insurers, State law empowers the insurance department to see to their fair treatment of policyholders and settlement of claims in accordance with contract terms.

Insurance Department Warns Public of Unlicensed Insurors

New York State residents were warned this week by the New York State Insurance Department that in dealing with insurers not authorized to do business in the State, "a New Yorker runs the risk of losing the benefit of safeguards against unreliability."

The department warning was prompted by recent mail campaigns of literature addressed to New York residents. One such campaign is being conducted by Automobile Owners Association of Kansas City, Mo., offering insurance with National Central Life Insurance Co. of Kansas City, Mo. The other consists of mailings to New York State residents by Firstpacific Life Insurance Co. of Reno, Nev. None of these is licensed in New York. No insurance company by either name is listed in standard reference sources which report on the financial condition of reliable insurance companies.

"Licensed companies must comply with specified financial requirements, must file annual reports of their financial condition, and are subject to thorough examination by the department concerning all phases of their operations, including claims handling," a Department statement points out. "The department passes upon premium rates and provisions of many types of insurance policies" of licensed companies.

Policyholders frequently have difficulties in obtaining satisfactory settlements of claims against unlicensed insurers. In the case of licensed insurers, State law empowers the insurance department to see to their fair treatment of policyholders and settlement of claims in accordance with contract terms.

The mailed literature of the Automobile Owner's Association, offers a limited-benefit travel accident policy issued by National Central Life Insurance Co., and includes as bait a promise of "$10,000 in cash prizes to safe drivers."

National Central and its agency have recently advertised widely and flooded a number of States with mailed solicitation. Insurance regulatory authorities of several other States have issued warnings to their residents against dealing with them.

The other unlicensed insurer, Firstpacific Life Insurance Co., offers by mail to sell insurance on the lives of servicemen to their parents. The company, organized in Nevada in 1958, does not meet the financial requirements which the New York insurance law imposes on licensed insurers for the public's protection.

Unlicensed Insurers, Insurance Adjusters, Agents, and Brokers

The department frequently receives inquiries about individuals and companies not licensed to do an insurance business in New York, particularly about out-of-State companies soliciting insurance through the mails, on radio or television, or in other multistate advertising media. Many such inquiries have been prompted by policyholders' difficulties in obtaining satisfactory settlements of claims against unlicensed insurers.

The New York insurance law requires that all who would act as insurance adjusters, agents, or brokers in this State must be licensed by the New York Insurance Department. For an insurance company to do business here it must also be licensed. All licensees are required to observe the applicable requirements of the New York law. For example, licensed companies must comply with specified financial requirements applicable to the kinds of insurance for which they are licensed, must file annual reports of their financial condition, and are subject to thorough examination by the department concerning all phases of their operations, including claims handling. The department must pass upon premium rates and provisions of many types of insurance policies sold by such companies before they are put in use. In various lines of insur-

ance, payments of obligations under policies sold by licensed insurers are guaranteed by funds established by New York law. These requirements were established for the protection of the interests of the people of this State and the department is not in position to give assurance that similar safeguards are observed by insurers not licensed in New York.

This is not a blanket condemnation of insurers which solicit and obtain insurance largely through the medium of the mails. There are several companies, even some licensed in New York which conduct their business in that manner, whose financial condition, management, and treatment of policyholders conform to the standards imposed by the provisions of the New York insurance law.

Notwithstanding the fact that there are reliable unlicensed companies, a New Yorker runs the risk of losing the benefit of safeguards against unreliability when he deals with a nonlicensee. For this reason, it is suggested that before committing yourself to insurance or insurance service you ascertain that it is provided under a New York license.

This list of licensed insurers is prepared, revised, and distributed yearly. The list is sent to all newspapers in the State, all radio and TV stations, various agents' associations, Better Business Bureaus, insurance information services and similar agencies, in order to provide the broadest possible distribution. Note the warning on page 2 as well as the cover page.

In addition, the department releases news stories periodically concerning this subject.

OHIO DEPARTMENT OF INSURANCE.

STATE OF NEW JERSEY,
DIVISION OF THE NEW JERSEY REAL ESTATE COMMISSION,
DEPARTMENT OF BANKING AND INSURANCE,
Newark, July 16, 1964.

U.S. Senate Subcommittee on Frauds and Misrepresentations Affecting the Elderly, Washington, D.C.:

In connection with the Leisure Village statement before the subcommittee, I am requesting you to make part of the record the enclosed memorandum from Associate Actuary Walter Young to Commissioner Charles R. Howell.

Sincerely,

ROBERT R. PEACOCK,
Secretary-Director.

Enclosure.

INTERCOMMUNICATION

STATE OF NEW JERSEY,
DEPARTMENT OF BANKING AND INSURANCE,
June 17, 1964.

Re Leisure Village—Supplement to my memo of June 17, 1964, to J. Adelman.

From: Walter Young, Associate Actuary.

To: Charles R. Howell, Commissioner.

It is fair to conclude from my memo that although we had filed the group master policy form effective October 24, 1963, that since this filing was only for general use, we did not authorize the issue of a group policy on this form to Leisure Village Association until after the company (Continental Casualty Co.) submitted further information about the eligibility of this proposed group on November 21, 1963, which was after the date of our meeting in Peacock's office. However, I still think the Leisure Village ad of September 13, 1963, was of major importance.

WALTER YOUNG.

PLEASE DESTROY ALL PREVIOUS LISTS

STATE OF OHIO

JAMES A. RHODES, Governor

DEPARTMENT OF INSURANCE

List of Insurance Companies Authorized To Transact Business in The State of Ohio as of July 1, 1963

Issued by

WILLIAM R. MORRIS

Director of Insurance
115 E. Rich Street
Columbus 15, Ohio

WARNING: The Citizens of Ohio are warned against purchasing insurance from companies not authorized to transact the business of insurance by certificate of authority issued by The Superintendent of Insurance of The State of Ohio. Compare your policies with this list. Buy insurance from licensed agents and authorized companies.

COMPANIES ADMITTED TO OHIO AFTER JULY 1, 1963

American Protection Ins. Co.....Chicago, Ill., S--C

Argonaut Ins. Co. (s).....Menlo Park, Cal., S--FC

Avemco Ins. Co.....Silver Spring,Md., S--C

Beneficial Life Ins. Co.....Salt Lake City, Utah,S--L

Capitol Life Ins. Co.....Denver, Colo., S--L

Community Health Foundation, Inc.....Cleveland, O., H--C

Fidelity Life Ins. Co.....Dallas, Tex., S--L

Great Northern Life Ins. Co.....Indianapolis, Ind.,S--L

Hamilton Life Ins. Co. of N.Y.....New York, N.Y., S--L

Leader Nat'l. Ins. Co.....Cleveland, O., S--FC

Life Ins. Co. of Ky.....Louisville, Ky., S--L

Nat'l.Union Life Ins.Co. of Pitts....Pittsburgh, Pa., S--L

Ohio State Dental Care Corp.....Columbus, O., D--C

Regent Ins. Co. (s).....Madison, Wis., S--FC

Save-T-Risk Ins. Co.....Columbus, O., S--FC

Security Life & Trust Co.....Winston Salem, N.C., S--L

Stonewall Jackson Life Ins. Co....Huntington, W.Va., S--L

Summit Nat'l. Life Ins. Co.....Akron, O., S--L

Transnational Life Ins. Co.....Los Angeles,Cal., S--L

Union Fidelity Life Ins. Co.....Philadelphia,Pa., S--L

United American Life Ins. Co.....Denver, Colo., S--L

Universal Guaranty Life Ins.Co. of O...Columbus, O., S--L

TO THE PEOPLE OF OHIO

This booklet contains a list of all insurance companies authorized to transact business in Ohio. An insurance company not listed is not licensed in Ohio, is not subject to our law, and does not pay taxes in this state. Such a company may not be examined by the Ohio Department of Insurance. Therefore, we have no knowledge of its financial condition, policy contracts, or practices regarding payment of claims.

Many unlicensed companies solicit insurance from residents of Ohio by mail from out of state. It is very difficult to prevent such solicitation. For your own protection therefore when you spend your money for insurance, be sure that the name of the company issuing your policy appears in this booklet. The Ohio Department of Insurance can be of little assistance to you if you are treated improperly by an unlicensed company.

WILLIAM R. MORRIS
Director of Insurance

33-761 O—64——13

INSURANCE COMPANIES AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF OHIO

As of July 1, 1963

The names of all companies authorized in Ohio with their corporate addresses are listed in alphabetical order. Symbols appearing after each name and address indicate the company classification as explained below:

The first symbol indicates the type of organization or company.

As, assessment company.
Fra. fraternal benefit society.
H, non-profit hospital service corporation.
M, mutual company.
R, reciprocal exchange.
S, stock company.

The second symbol indicates the general type of business for which the company is authorized in Ohio.

A, accident only.
C, casualty which may include insurance other than life, fire, title and hospitalization as written by non-profit hospital service corporations. It may include sickness and accident and surety, either or both. Names of companies authorized to write surety are followed by (s).
F, fire and allied lines only.
FC, fire and casualty.
FL, fraternal life insurance.
H, hospitalization insurance as written by non-profit hospital service corporations.
HC, health care insurance as written by non-profit associations.
L, life insurance. Names of companies writing sickness and accident insurance also are followed by (*).
S, sickness and accident insurance only.
T, title insurance only.

Abbreviations used in company names:

Accident, Acc.; America, A.; Association, Ass'n.; Assurance, Assur.; Casualty, Cas.; Company, Co.; Corporation, Corp.; Fidelity, Fid.; Fraternal, Fra.; General, Gen'l.; Hospital, Hosp.; Indemnity, Ind.; Insurance, Ins.; Liability, Liab.; National, Nat'l.; Organization, Org.; Reciprocal, Rec.; Reinsurance, Reins.; Society, Soc.; Surety, Sur.; Township, Twp.

AUTHORIZED LIST

See the preceding page for meaning of abbreviations used in names and symbols indicating classifications.

(A)

Company Name	Corporate Address & Classification
Abington Mut. Fire Ins. Co.	Abington, Mass., M — FC
Acacia Mut. Life Ins. Co.	Washington, D. C., M — L
Acc. & Cas. Ins. Co. of Winterthur, Switz. (s)	Winterthur, Switz., S — FC
U. S. Address	New York, N. Y.
Aetna Cas. & Sur. Co., The (s)	Hartford, Conn., S — FC
Aetna Ins. Co. (s)	Hartford, Conn., S — FC
Aetna Life Ins. Co. (*)	Hartford, Conn., S — L
Affiliated F M Ins. Co.	Providence, R. I., S — FC
Agricultural Ins. Co. (s)	Watertown, N.Y., S — FC
Aid Ass'n for Lutherans	Appleton, Wis., Fra — FL
Albany Ins. Co.	Albany, N. Y. S — FC
All America Ins. Co. (s)	Van Wert, O., S — FC
All American Life & Cas. Co. (*)	Park Ridge, Ill., S — L
Allegheny Mut. Cas. Co. (s)	Meadville, Pa., M — C
Allen County Mut. Ins. Ass'n. The	Lima, O., As — F
Alliance of Poles of A.	Cleveland, O., Fra — FL
~~Allied American Mut. Fire Ins. Co.~~	~~Wakefield, Mass., M — FC~~
Allstate Fire Ins. Co.	Skokie, Ill., S — F
Allstate Ins. Co. (s)	Skokie, Ill., S — FC
Allstate Life Ins. Co. (*)	Skokie, Ill., S — L
Amalgamated Labor Life Ins. Co. (*)	Chicago, Ill., S — L
American Automobile Ins. Co. (s)	St. Louis, Mo., S — FC
American Bankers Ins. Co. of Fla.	Miami, Fla., S — FC
American Bankers Life Assur. Co. of Fla. (*)	Miami, Fla., S — L
American Cas. Co. of Reading, Pa. (s)	Reading, Pa., S — FC
American Central Ins. Co. (s)	St. Louis, Mo. S — FC
American Consumer Ins. Co.	Westbury, N. Y., S — FC
American Credit Ind. Co. of N. Y.	New York, N. Y., S — C
American Druggists' Ins. Co. (S)	Cincinnati, O. S — FC
American Economy Ins. Co.	Indianapolis, Ind., S — FC
American Empire Ins. Co. of S.D.	Sioux Falls, S.D., S — FC
American Employers' Ins. Co. (s)	Boston, Mass., S — FC
American Equitable Assur. Co. of N. Y.	New York, N. Y., S — FC
American Fid. & Cas. Co., Inc.	Richmond, Va., S — FC
American Fidelity Fire Ins. Co.	New York, N.Y., S — F
American Fire & Ind. Co.	Galveston, Tex., S — FC
American & Foreign Ins. Co. (s)	New York, N. Y., S — FC
American Fraternal Union	Ely, Minn., Fra — FL
American Gen'l Ins. Co.	Houston, Tex., S — FC
American Gen'l Life Ins. Co. of Del.	Wilmington, Del., S — L
American Guarantee & Liab. Ins. Co. (s)	New York, N. Y., S — FC
American Hardware Mut. Ins. Co.	Minneapolis, Minn., M — FC
American Health & Life Ins. Co. (*)	Baltimore, Md., S — L
American Heritage Life Ins. Co. (*)	Jacksonville, Fla., S — L

* Name Changed to
American Mut. Ins. Co. of Boston

Company Name	Corporate Address & Classification
American Home Assur. Co. (s)	New York, N. Y., S — FC
~~American Home Mut. Life Ins. Co. (*)~~ 4-29-64	~~Washington, D. C., M — L~~
American Hungarian Catholic Soc.	Cleveland, O., Fra — FL
American Income Life Ins. Co. (*)	Indianapolis, Ind., S — L
American Ind. Co. (s)	Galveston, Tex., S — FC
American Ins. Co., The (s)	Newark, N. J., S — FC
American Liberty Ins. Co.	Birmingham, Ala., S — FC
American Life & Acc. Ins. Co. of Ky. (*)	Louisville, Ky., S — L
American Life Ins. Ass'n., The	Bridgeport, Conn., Fra — FL
American Life Ins. Co. of N. Y., The (*)	New York, N. Y., S — L
American Manufacturers Mut. Ins. Co. (s)	New York, N. Y., M — FC
American Mercury Ins. Co.	Washington, D. C., S — C
American Motorists Ins. Co. (s)	Chicago, Ill., S — FC
American Mut. Liab. Ins. Co. (s)	Wakefield, Mass., M — FC
American Mut. Reins. Co. (s)	Chicago, Ill., M — FC
American Nat'l Fire Ins. Co. (s)	New York, N. Y., S — FC
American Nat'l Ins. Co. (*)	Galveston, Tex., S — L
American Policyholders' Ins. Co.	Wakefield, Mass., S — C
American Progressive Health Ins. Co. of N. Y.	Mt. Vernon, N. Y., S — C
American Reciprocal Insurers, Rec. Mgrs., Inc., Att'y-in-Fact	New York, N. Y., R — F
American Re-Ins. Co. (s)	New York, N. Y., S — FC
American Republic Ins. Co. (*)	Des Moines, Ia., M — L
American Road Ins. Co., The (S)	Dearborn, Mich., S — C
American Russian Nat'l Brotherhood	Cleveland, O., Fra — FL
American Security Ins. Co.	Atlanta, Ga., S — FC
American Select Risk Ins. Co.	Columbus, O., S — FC
American Slovenian Catholic Union	Joliet, Ill., Fra — FL
American Star Ins. Co., The	New York, N. Y., S — FC
American States Ins. Co. (s)	Indianapolis, Ind., S — FC
American States Life Ins. Co. (*)	Indianapolis, Ind., S — L
~~American Surety Co. of N. Y. (s)~~ 12-31-63	~~New York, N. Y., S — FC~~
American Title Ins. Co.	Miami, Fla., S — T
American United Life Ins. Co. (*)	Indianapolis, Ind., M — L
American Universal Ins. Co. (s)	Providence, R. I. S — FC
Arkwright Mut. Ins. Co.	Boston, Mass., M — FC
Associated Hosp. Service, Inc.	Youngstown, O. H — H
Associated Ind. Corp. (s)	San Francisco, Calif., S — FC
Associates Life Ins. Co. (*)	Indianapolis, Ind., S — L
Ass'n. Ins. Co., Inc. (*)	Milwaukee, Wis., S — L
Assn. of Lithuanian Workers	Ozone Park, N. Y., Fra — FL
Ass'n. of Polish Women in the U. S.	Cleveland, O., Fra — FL
Assurance Co. of Am. (s)	New York, N. Y., S — FC
Atlanta Life Ins. Co. (*)	Atlanta, Ga., S — L
Atlantic Ins. Co. (s)	Dallas, Tex., S — FC
Atlantic Mut. Ins. Co. (s)	New York, N. Y., M — FC
Atlas Assur. Co., Ltd.	London, Eng., S — FC
U. S. Address	New York, N. Y.
Auto-Owners (Mut.) Ins. Co. (s)	Lansing, Mich., M — FC

Company Name	Corporate Address & Classification
Automobile Club Ins. Co.	Columbus, O., S — C
Automobile Mut. Ins. Co. of A.	Providence, R. I., M — FC
Autoplan Ins. Co.	New York, N. Y., S — FC

(B)

Badger Mut. Ins. Co.	Milwaukee, Wis., M — FC
Balboa Ins. Co.	Los Angeles, Cal., S — FC
Baltimore Life Ins. Co. (*)	Baltimore, Md., M — L
~~Bankers Ins. Co. of Pa.~~	~~Gettysburg, Pa., S — FC~~
Bankers Life & Cas. Co. (*)	Chicago, Ill., S — L
Bankers Life Co. (*)	Des Moines, Ia., M — L
Bankers Life Ins. Co. of Nebr. (*)	Lincoln, Nebr., M — L
Bankers Multiple Line Ins. Co. (s)	Dubuque, Ia., S — FC
Bankers Mut. Ins. Co. of the District of Columbia	Washington, D. C., M — F
Bankers National Life Ins. Co. (*)	Montclair, N. J., S — L
Bankers Security Life Ins. Soc. (*)	New York, N. Y., S — L
Bankers & Shippers Ins. Co. of N. Y. (s)	New York, N. Y., S — FC
Baptist Life Ass'n	Buffalo, N. Y., Fra — FL
Bay State Ins. Co.	Andover, Mass., S — FC
Beacon Mut. Ind. Co., The (s)	Columbus, O., M — FC
Belmont Ins. Ass'n., The	Barnesville, O., As — F
Beneficial Fire & Cas. Ins. Co.	Los Angeles, Calif., S — FC
Beneficial Standard Life Ins. Co. (*)	Los Angeles, Calif., S — L
Benefit Trust Life Ins. Co., (A Mut. Legal Reserve Life Ins. Co.) (*)	Chicago, Ill., M — L
Ben Hur Life Ass'n	Crawfordsville, Ind., Fra — FL
Berks Title Ins. Co.	Reading, Pa., S — T
Berkshire Life Ins. Co. (*)	Pittsfield, Mass., M — L
Berkshire Mut. Ins. Co.	Pittsfield, Mass., M — FC
Birmingham Fire Ins. Co. of Pa. (s)	Pittsburgh, Pa., S. — FC
Bituminous Cas. Corp.	Rock Island, Ill., S — C
Bituminous Fire & Marine Ins. Co.	Rock Island, Ill., S — C
Blackstone Mut. Ins. Co.	Providence, R. I., M — FC
Blue Cross of Northeast Ohio	Cleveland, Ohio H — H
Bnai Zion	New York, N. Y., Fra — FL
Boston Ind. Ins. Co. (s)	Boston, Mass., S — FC
Boston Ins., Co. (s)	Boston, Mass., S — FC
Boston Manufacturers Mut. Ins. Co.	Waltham, Mass., M — FC
British & Foreign Marine Ins. Co., Ltd.	Liverpool, Eng., S — F
U. S. Address	New York, N. Y.
Brotherhood (Mut.) Ins. Co.	Ft. Wayne, Ind., M — FC
Brotherhood Mut. Life Ins. Co. (*)	Ft. Wayne, Ind., M — L
Brotherhood of R. R. Trainmen, Ins. Dept.	Cleveland, O., Fra — FL
Buckeye State Mut. Farm & Home Ins. Co.	Covington, O., As — F
Buckeye State Mut. Ins. Ass'n, The	Covington, O., As — F
Buckeye Union Cas. Co., The (s)	Columbus, O., S — FC
Buckeye Union Fire Ins. Co., The (s)	Columbus, O., S — FC
Buffalo Ins. Co. (s)	Buffalo, N. Y., S — FC
Business Men's Assur. Co. of A. (*)	Kansas City, Mo., S — L
Butler & Goshen Twps Mut. Aid Soc.	Damascus, O., As — F

* Name Changed to:
Bankers & Telephone Employees Ins. Co.

Company Name	Corporate Address & Classification
(C)	
Caledonian Ins. Co.	Edinburgh, Scot., S — C
U. S. Address	New York, N. Y.
California Ins. Co., The	San Francisco, Cal., S — FC
Calvert Fire Ins. Co.	Philadelphia, Pa., S — F
Cambridge Mut. Fire Ins. Co. (s)	Andover, Mass., M — FC
Camden Fire Ins. Ass'n (s)	Camden, N. J., S — FC
Canada Life Assur. Co. (*)	Toronto, Canada, M — L
Canal Ins. Co.	Greenville, S. C., S — FC
Canners Exchange Subscribers at Warners' Inter-Ins. Bureau, Lansing B. Warner, Inc. Att'y-in-Fact	Chicago, Ill., R — FC
Capitol Ins. Co. of O.	Cleveland, O., As — S
Carolina Cas. Ins. Co. (s)	Burlington, N. C., S — C
Carriers Ins. Co.	Des Moines, Ia., S — FC
Cas. Reciprocal Exchange, Bruce Dodson, Att'y-in-Fact	Kansas City, Mo., R — FC
Catholic Central Union	St. Louis, Mo., Fra — FL
Catholic Knights of A.	St. Louis, Mo., Fra — FL
Catholic Knights of O., The	Lakewood, O., Fra — FL
Catholic Knights of St. George	Pittsburgh, Pa., Fra — FL
Catholic Ladies of Columbia, The	Columbus, O., Fra — FL
Catholic Order of Foresters	Chicago, Ill., Fra — FL
Catholic Slovak Benefit Organization of the State of Ohio	Cleveland, O., Fra — FL
Catholic Workman	New Prague, Minn., Fra — FL
Cavalier Ins. Corp.	Baltimore, Md., S — F
Celina Mut. Ins. Co., The (s)	Celina, O., M — FC
Centennial Ins. Co. (s)	New York, N. Y., S — FC
Central Assur. Co. (*)	Warren County, O., M — L
Central Hosp. Service Ass'n	Columbus, O., H — H
Central Life Assur. Co.	Des Moines, Ia., M — L
Central Mut. Fire Ins. Ass'n, The	Hillsboro, O., As — F
Central Mut. Ins. Co. (s)	Van Wert, O., M — FC
Central Nat'l Ins. Co. of Omaha, The	Omaha, Nebr., S — FC
Central Nat'l Life Ins. Co. of Omaha, The (*)	Omaha, Nebr., S — L
Central Standard Life Ins. Co. (*)	Chicago, Ill., S — L
Central States Health & Life Co. of Omaha (*)	Omaha, Nebr., M — L
Central Surety & Ins. Corp. (s)	Kansas City, Mo., S — FC
Central Verband Der Siebenburger-Sachsen of the U. S.	Cleveland, O., Fra — FL
Century Ins. Co., Ltd.	Edinburgh, Scot., S — FC
U. S. Address	New York, N. Y.
Charter Nat'l Life Ins. Co. (*)	St. Louis, Mo., S — L
Charter Oak Fire Ins. Co., The	Hartford, Conn., S — FC
Chelsea Title & Guaranty Co.	Atlantic City, N.J., S — T
Chesapeake Ins. Co., The	Easton, Md., S — FC
Chesapeake Life Ins. Co. (*)	Baltimore, Md., S — L
Chicago Metropolitan Mut. Assur. Co.	Chicago, Ill., M — L
Christiana Gen'l. Ins. Corp. of N. Y. (s)	Tarrytown, N. Y., S — FC
Church Fire Ins. Corp., The	New York, N. Y., S — FC
Church Mut. Ins. Co. (s)	Merrill, Wis., M — FC

Company Name	Corporate Address & Classification
Cincinnati Equitable Ins. Co	Cincinnati, O., M — F
Cincinnati Ins. Co., The (s)	Cincinnati, O., S — FC
Citizens Ins. Co. of New Jersey (s)	Jersey City, N. J., S — FC
Citizens Life Ins. Co. of N. Y.	New York, N. Y., S — L
~~Citizens Nat'l Life Ins. Co. (*)~~ 12-27-63	~~Indianapolis, Ind., S — L~~
City Title Ins. Co	New York, N. Y., S — T
Clark County Farmers' Mut. Protection & Aid Ass'n	Springfield, O., As — F
Cleveland Ins. Exchange, Cleveland Underwriting Co., Att'y-in-Fact	Cleveland, O., R — F
Clinton Mut. Ins. Ass'n	Wilmington, O., As — F
College Life Ins. Co. of A., The	Indianapolis, Ind., S — L
Colonial Assur. Co	Philadelphia, Pa., S — FC
Colonial Heritage Life Ins. Co	Leroy, O., S — L
Colonial Ins. Co	Cleveland, O., As — S
Colonial Life Ins. Co. of A., The (*)	E. Orange, N. J., S — L
~~Columbia Cas. Co. (s)~~ 12-31-63	~~New York, N.Y., S — C~~
Columbian Mut. Life Ins. Co. (*)	Binghamton, N.Y., M — L
Columbus Mut. Life Ins. Co., The (*)	Columbus, O., S — L
Combined Ins. Co. of A	Chicago, Ill., S — C
Commerce & Industry Ins. Co	New York, N. Y., S — FC
Commercial Ins. Co. of Newark, N. J. (s)	Newark, N. J., S — FC
Commercial Standard Ins. Co	Ft. Worth, Tex., S — T
~~Commercial Union Assur. Co., Ltd.~~ 12-31-63	~~London, Eng., S — FC~~
~~U. S. Address~~	~~New York, N. Y.~~
Commercial Union Ins. Co. of N. Y., The (s)	New York, N. Y., S — FC
Commonwealth Land Title Ins. Co	Philadelphia, Pa., S — T
Commonwealth Life & Acc. Ins. Co. (*)	St. Louis, Mo., S — L
Commonwealth Life Ins. Co. (*)	Louisville, Ky., S — L
Confederation Life Ass'n. (*)	Toronto, Canada, S — L
Connecticut Fire Ins. Co., The (s)	Hartford, Conn., S — FC
Connecticut Gen'l. Life Ins. Co. (*)	Bloomfield, Conn., S — L
Connecticut Ind. Co., The (s)	New Haven, Conn., S — FC
Connecticut Mut. Life Ins. Co	Hartford, Conn., M — L
Consolidated American Ins. Co. (s)	Columbia, S. C., S — FC
Consolidated Ins. Co. (s)	Indianapolis, Ind., S — FC
Consolidated Mut. Ins. Co. (s)	Brooklyn, N. Y., M — FC
Consolidated Underwriters, T. H. Mastin & Co., Att'y-in-Fact	Kansas City, Mo., R — FC
Constellation Ins. Co. (s)	New York, N. Y., S — FC
Constitution Ins. Corp., The	New York, N. Y., S — F
Constitution Life Ins. Co. (*)	Chicago, Ill., S — L
Consumers Nat'l. Life Ins. Co. (*)	Evansville, Ind., S — L
Continental American Life Ins. Co. (*)	Wilmington, Del., S — L
Continental Assur. Co. (*)	Chicago, Ill., S — L
Continental Cas. Co. (s)	Chicago, Ill., S — FC
Continental Ins. Co., The (s)	New York, N. Y. S — FC
Copenhagen Reins. Co., Ltd., The	Copenhagen, Denmark, S — F
U. S. Address	New York, N. Y.
Covington Mut. Ins. Co	Covington, Ky., M — FC
Craftsman Life Ins. Co. (*)	Boston, Mass., S — L
Crawford County Farmers' Mut. Fire Ins. Co	Bucyrus, O., As — F

Company Name	Corporate Address & Classification
Credit Life Ins. Co. (*)	Springfield, O., S — L
Criterion Ins. Co.	Washington, D. C., S — C
Croatian Catholic Union of U. S. A.	Gary, Ind., Fra — FL
Croatian Fraternal Union of A.	Pittsburgh, Pa., Fra — FL
Crown Life Ins. Co. (*)	Toronto, Canada, S — L
Cumis Ins. Soc., Inc.	Madison, Wis., S — FC
Cuna Mut. Ins. Soc. (*)	Madison, Wis., M — L
Czech Catholic Union	Cleveland, O., Fra — FL
Czechoslovak Soc. of A.	Cicero, Ill., Fra — FL

(D)

Danish Brotherhood in A.	Omaha, Nebr., Fra — FL
Darke County Mut. Cyclone Ins. Co., The	Greenville, O., As — F
Degree of Honor Protective Ass'n	Sioux Falls, S. D., Fra — FL
Delaware County Farmers' Mut. Fire Ins. Co., The	Sunbury, O., As — F
~~Dixie Fire & Cas. Co., The~~	~~Greer, S. C., S — FC~~
Dominion Life Assur. Co. (*)	Waterloo, Canada, S — L
Druggist Ind. Exchange, Manlin Service, Corp., Att'y-in-Fact	St. Louis, Mo., R — F

(E)

Eagle Star Ins. Co., Ltd.	London, Eng., S — F
U. S. Address	New York, N. Y.
Eagles' Nat'l Life Ins. Co. (*)	Cincinnati, O., S — L
Eastern Ohio Mut. Fire & Tornado Ins. Co., The (P. O. Freeport)	Londonderry, O., As — F
Economy Fire & Cas. Co. (5)	Freeport, Ill., S — FC
~~Educator & Executive Associated Ins. Co.~~ 12-31-63	~~Columbus, O., S — FC~~
Educator & Executive Insurers, Inc.	Columbus, O., S — FC
Educator & Executive Life Ins. Co.	Columbus, O., S — L
Educators Mut. Life Ins. Co. (*)	Lancaster, Pa., M — L
Electric Mut. Liab. Ins. Co. (s)	Lynn, Mass., M — FC
Elevators Mut. Ins. Ass'n, The	Lima, O., M — FC
Emmco Ins. Co.	South Bend, Ind., S — F
Empire State Mut. Life Ins. Co. (*)	Jamestown, N. Y., M — L
Employees Mut. Benefit Ass'n. of Saint Paul (*)	St. Paul, Minn., M — L
Employers' Fire Ins. Co., The (s)	Boston, Mass., S — FC
Employers' Liab. Assur. Corp., Ltd., The (s)	London, Eng., S — FC
U. S. Address	Boston, Mass.
Employers' Life Ins. Co. of Am., The (*)	Wilmington, Del., S — L
Employers Mut. Cas. Co. (s)	Des Moines, Ia., M — FC
Employers Mut. Fire Ins. Co. (s)	Wausau, Wis., M — FC
Employers Mut. Liab. Ins. Co. of Wis. (s)	Wausau, Wis., M — FC
Employers Reins. Corp. (s)	Kansas City, Mo., S — C
Equitable Fire & Marine Ins. Co. (s)	Providence, R. I., S — FC
Equitable Life Assur. Soc. of the U. S., The (*)	New York, N. Y., M — L
Equitable Life Ins. Co.	Washington, D. C., S — L
Equitable Life Ins. Co. of Iowa	Des Moines, Ia., S — L
Equity Ins. Ass'n of Delphos, O.	Delphos, O., As — F
Erie County Farmers Ins. Co.	Sandusky, O., As — F

* Name Changed to:
Southern Home Ins Co.

Company Name	Corporate Address & Classification
Excel Ins. Co.	South Bend, Ind., S — FC
Excelsior Ins. Co. of N. Y. (s)	Syracuse, N. Y., S — FC
Excess Mut. Rein. Co.	Wilmington, Del., M — FC
Export Ins. Co.	New York, N.Y., S — FC

(F)

Factory Mut. Liab. Ins. Co. of A	Providence, R. I., M — C
Fairfield County Farmers' Mut. Fire Ins. Co., The	Lancaster, O., As — F
Farband-Labor Zionist Order	New York, N. Y., Fra — FL
Farmer Mut. Fire Protection Ass'n of Defiance County, The	Farmer, O., As — F
Farmers Alliance Mut. Ins. Co.	McPherson, Kans., M — FC
Farmers Equitable Ins. Co.	Elmhurst, Ill., S — C
Farmers Fire Ins. Co., The (s)	York, Pa., S — FC
Farmers' Home Mut. Fire Ins. Co., The	New Knoxville, O., As — F
Farmers' Mut. Aid Ass'n, The	Ottoville, O., As — F
Farmers' Mut. Aid Ass'n of Van Wert County, The	Van Wert, O., As — F
Farmers' Mut. Fire Ins. Co. of Darke County	Greenville, O., As — F
Farmers' Mut. Fire & Lightning Ins. Ass'n of Medina County	Medina, O., As — F
Farmers Mut. Hail Ins. Co. of Ia.	Des Moines, Ia., M — F
Farmers' Mut. Home Ins. Co.	Elyria, O., As — F
Farmers' Mut. Ins. Ass'n of Seneca County, Ohio, The	Tiffin, O., As — F
Farmers' Mut. Ins. Co.	Winchester, O., As — F
Farmers' Mut. Ins. Co., of Harrison County, The	Cadiz, O., As — F
Farmers' Mut. Protective Ass'n of Hancock County, Ohio, The	Findlay, O., As — F
Farmers' Mut. Relief Ass'n of Sandusky County, The	Fremont, O., As — F
Farmers' Mut. Relief Ass'n, The	Upper Sandusky, O., As — F
~~Farmers' Mut. Union Fire Ins. Co.~~ 3-20-64	~~Madison Mills, O., As — F~~
Farmers and Traders Life Ins. Co. (*)	Syracuse, N. Y., S — L
Federal Ins. Co. (s)	Short Hills, N. J., S — FC
Federal Life & Cas. Co. (*)	Battle Creek, Mich., S — L
Federal Life Ins. Co. (Mut.) (*)	Chicago, Ill., M — L
Federal Mut. Ins. Co. (s)	Chicago, Ill., M — FC
Federated Mut. Implement & Hardware Ins. Co. (s)	Owatonna, Minn., M—FC
Federation Life Ins. of A.	Milwaukee, Wis., Fra — FL
Fidelity & Cas. Co. of N. Y., The (s)	New York, N. Y., S — FC
Fidelity & Deposit Co. of Md. (s)	Baltimore, Md., S — FC
Fidelity & Guaranty Ins. Underwriters, Inc. (s)	Columbus, O., S — FC
Fidelity & Guaranty Life Ins. Co. (*)	Baltimore, Md., S — L
Fidelity Bankers Life Ins. Co. (*)	Richmond, Va., S — L
Fidelity Interstate Life Ins. Co. (*)	Philadelphia, Pa., S — L
Fidelity Life Ass'n, A Mut. Legal Reserve Co. (*)	Fulton, Ill., M — L
Fidelity Life and Income Mut. Ins. Co. (*)	Benton Harbor, Mich., M — L
Fidelity Mut. Life Ins. Co., The	Philadelphia, Pa., M — L
Fidelity Nat'l. Life Ins. Co.	Columbus, O., S — L
Fidelity-Phenix Ins. Co. (s)	New York, N. Y., S — FC
Fire & Cas. Ins. Co. of Conn., The	Hartford, Conn., S — FC
Fireman's Fund Ins. Co. (s)	San Francisco, Cal., S — FC
Firemen's Ins. Co. of Newark, N. J. (s)	Newark, N. J., S — FC

Company Name	Corporate Address & Classification
Firemen's Mut. Ins. Co.	Providence, R. I., M — FC
First Catholic Slovak Ladies' Union of the U. S. of A., The	Cleveland, O., Fra — FL
First Catholic Slovak Union of the U. S. A.	Cleveland, O., Fra — FL
First Nat'l Ins. Co. of A.	Seattle, Wash., S — FC
First Slovak Wreath of the Free Eagle, The	Bridgeport, Conn., Fra — FL
Florists & Gardeners' Ins. Ass'n. The	Cleveland, O., As — F
Florists' Mut. Ins. Co.	Edwardsville, Ill., M — FC
Foremost Ins. Co.	Grand Rapids, Mich., S —FC
Franklin Life Ins. Co.	Springfield, Ill., S — L
Fremont Mut. Ins. Ass'n	Fremont, O., As — F
French Union Ins. & Reins. Co. (s)	Paris, France, S — FC
U. S. Address	New York, N. Y.
Fulton Ins. Co., The (s)	New York, N. Y., S — FC

(G)

Gen'l. Acc. Fire & Life Assur. Corp., Ltd. (s)	Perth, Scotland, S — FC
U. S. Address	Philadelphia, Pa.
Gen'l. American Life Ins. Co. (*)	St. Louis, Mo., M — L
Gen'l. Cas. Co. of Wis.	Madison, Wis., S — FC
Gen'l. Fire & Cas. Co. (s)	New York, N. Y., S — FC
Gen'l. Ins. Co. of A. (s)	Seattle, Wash., S — FC
Gen'l. Ins. Co. of Trieste & Venice, The	Rome, Italy, S — FC
U. S. Address	New York, N. Y.
Gen'l. Life Ins. Co.	Cleveland, O., S — L
Gen'l. Reins. Corp (s)	New York, N. Y., S — FC
Gen'l. Reins. Life Corp. (*)	New York, N.Y., S — L
Gen'l. Security Assur. Corp of N. Y. (s)	New York, N. Y., S — FC
Georgia International Life Ins. Co. (*)	Atlanta, Ga., S — L
German Farmers' Mut. Fire Ins. Co.	New Bremen, O., As — F
German Farmers' Mut. Ins. Ass'n., The	Morton, O., As — F
German Farmers' Mut. Windstorm Ass'n.	New Bremen, O., As — F
German Mut. Fire Ins. Ass'n of Henry & Defiance Counties	Defiance, O., As — F
German Mut. Ins. Ass'n of Glandorf, O.	Glandorf, O., As — F
German Mut. Ins. Co. of Delphos, O.	Delphos, O., As — F
Germantown [redacted] Ins. Co.	Philadelphia, Pa., S — FC
Girardian Ins. Co. (*)	Dallas, Texas., S — L
Gleaner Life Ins. Soc.	Birmingham, Mich., Fra — FL
Glens Falls Ins. Co. (s)	Glens Falls, N. Y., S — FC
Globe Assur. Co. (*)	Columbus, O., S — L
Globe Ind. Co. (s)	New York, N. Y., S — FC
Globe Life Ins. Co. (*)	Chicago, Ill., S — L
Globe Mut. Cas. Co.	Cleveland, O., M — FC
Globe Security Ins. Co. (s)	Chicago, Ill., S — FC
Goodville Mut. Cas. Co.	Goodville, Pa., M — C
Government Employees Ins. Co.	Washington, D. C., S — FC
Government Employees Life Ins. Co. (*)	Washington, D. C., S — L
Grain Dealers Mut. Ins. Co. (s)	Indianapolis, Ind., M — FC
Grange Mut. Cas. Co. (s)	Columbus, O., M — FC
Granite State Ins. Co. (s)	Manchester, N. H., S — FC

Company Name	Corporate Address & Classification
Great American Ins. Co. (s)	New York, N. Y., S — FC
Great American Life Ins. Co. (*)	E. Orange, N. J., S — L
Great Central Ins. Co. (s)	Peoria, Ill., S — FC
Great Lakes Ins. Co	Toledo, O., S — FC
Great Lakes Mut. Life Ins. Co	Detroit, Mich., M — L
Great Lakes Protective Ass'n, Robert G. McCreary, Att'y-in-Fact	Cleveland, O., R — F
Great-West Life Assur. Co. (*)	Winnipeg, Canada, S — L
Greater Beneficial Union of Pittsburgh	Pittsburgh, Pa., Fra — FL
Greek-Catholic Union of the U. S. A.	Pittsburgh, Pa., Fra — FL
Guarantee Co. of N. A., The	Montreal, Canada, S — C
U. S. Address	New York, N. Y.
Guarantee Ins. Co	Los Angeles, Cal., S — FC
Guarantee Mut. Assur. Co. of A	Worcester, Mass., M — FC
Guarantee Mut. Life Co. (*)	Omaha, Neb., M — L
Guarantee Reserve Life. Ins. Co. ~~of Hammond~~ (*)	Hammond, Ind., S — L
Guarantee Trust Life Ins. Co	Chicago, Ill., M—L
Guaranty Security Ins. Co	Minneapolis, Minn., S—FC
Guardian Life Ins. Co., of A., The (*)	New York, N.Y., M—L
Gulf Ins. Co. (s)	Dallas, Tex., S—FC

(H)

Hamilton Mut. Ins. Co. of Cincinnati, O., The (s)	Cincinnati, O., M — FC
Hancock Mut. Ins. Ass'n	Findlay, O., As — F
Hanover Ins. Co., The (s)	New York, N. Y., S — FC
Hardware Dealers Mut. Fire Ins. Co	Stevens Point, Wis., M — FC
Hardware Mut. Cas. Co. (s)	Stevens Point, Wis., M — FC
Harford Mut. Ins. Co., The	Bel Air, Md., M — FC
Harleysville Mut. Cas. Co	Harleysville, Pa., M — FC
Harleysville Mut. Ins. Co. (s)	Harleysville, Pa., M — FC
Hartford Acc. and Ind. Co. (s)	Hartford, Conn., S — FC
Hartford Fire Ins. Co. (s)	Hartford, Conn., S — FC
Hartford Life Ins. Co. (*)	Boston, Mass., S — L
Hartford Live Stock Ins. Co	New York, N. Y., S — C
Hartford Steam Boiler Insp. & Ins. Co., The	Hartford, Conn., S — C
Hawkeye-Security Ins. Co. (s)	Des Moines, Ia., S — FC
Health Care Mut. Ass'n	Cincinnati, O., M — C
Health Service, Inc	Chicago, Ill., S — C
Henry County Mut. Ins. Ass'n	Napoleon, O., As — F
Holland-America Ins. Co. (s)	Kansas City, Mo., S — FC
Holyoke Mut. Fire Ins. Co	Salem, Mass., M — F
Home Fire & Marine Ins. Co. of Calif.	San Francisco, Calif., S — FC
Home Ind. Co., The (s)	New York, N. Y., S — C
Home Ins. Ass'n of Fremont, O	Fremont, O., As — F
Home Ins. Co., The (s)	New York, N. Y., S — FC
Home Life Ins. Co. (*)	New York, N. Y., M — L
Home Mut. Ins. Co. of Binghamton, N. Y.	Binghamton, N. Y., M — FC
Horace Mann Life Ins. Co. (*)	Springfield, Ill., S — L
Hospital Care Corp	Cincinnati, O., H — H
Hospital Service Ass'n of Licking County, Inc	Newark, O., H — H
Hospital Service Ass'n of Toledo	Toledo, O., H — H

Company Name	Corporate Address & Classification
Hospital Service, Inc., of Lima, O.	Lima, O., H — H
Hospital Service, Inc., of Stark County	Canton, O., H — H
Hudson Ins. Co	New York, N. Y., S — F
Hungarian Reformed Federation of A., The	Washington, D. C., Fra — FL
Huron County Farmers' Ins. Co	North Fairfield, O., As — F

(I)

Ideal Mut. Ins. Co	New York, N. Y., M — C
Illinois Ins. Co. (s)	Chicago, Ill., S — FC
Illinois Mut. Life & Cas. Co. (*)	Peoria, Ill., M — L
Illinois Nat'l Ins. Co. (s)	Springfield, Ill., S — FC
Imperial Cas. & Ind. Co	Omaha, Nebr., S — FC
Indemnity Marine Assur. Co., Ltd., The	London, Eng., S — FC
U. S. Address	New York, N. Y.
Independence Life & Acc. Ins. Co. (*)	Louisville, Ky., S — L
Independent Order of Foresters, The	Toronto, Canada, Fra — FL
Independent Reciprocal Exchange, Independent Reciprocal Service, Inc., Att'y-in-Fact	St. Louis, Mo., R — F
Indiana Ins. Co. (s)	Indianapolis, Ind., S — FC
Indiana Lumbermens Mut. Ins. Co. (s)	Indianapolis, Ind., M — FC
Indiana Mut. Hail Ins. Co	Indianapolis, Ind., M — F
Indiana Retail Merchants Ass'n Mut. Fire Ins. Co., The	Indianapolis, Ind., M — F
Indiana Union Mut. Ins. Co	Indianapolis, Ind., M — FC
Indianapolis Life Ins. Co. (*)	Indianapolis, Ind., M — L
Inland Mut. Ins. Co	Huntington, W. Va., M — FC
Inland Nat'l. Ins. Co. (s)	Springfield, Ill., S — FC
Insurance City Life Co. (*)	Hartford, Conn., S — L
Ins. Co. of N. A. (s)	Philadelphia, Pa., S — FC
Ins. Co. of St. Louis	St. Louis, Mo., S — FC
Ins. Co. of the State of Pa., The (s)	Philadelphia, Pa., S — FC
Interboro Mut. Ind. Ins. Co	New York, N. Y., M — C
Inter-County Title Guaranty and Mortgage Co	Floral Park, N. Y., S — T
International Ins. Co. (s)	New York, N. Y., S — FC
Inter-Ocean Ins. Co. (Cincinnati) (*)	Indianapolis, Ind., S — L
~~Inter-Ocean Reins. Co. (s)~~ 12-31-63	~~Cedar Rapids, Ia., S — FC~~
Inter-State Assur. Co., A Mut. Co. (*)	Des Moines, Ia., M — L
Interstate Ins. Co	Cranford, N.J., S — F
Investment Life Ins. Co. of Am. (*)	Cleveland, O., S — L
Investors Nat'l. Life Ins. Co. (*)	Marion, Ind., S — L
Investors Syndicate Life Ins. & Annuity Co	Minneapolis, Minn., S — L
Italo-American Nat'l Union	Chicago, Ill., Fra — FL

(J)

Jackson Mut. Ins. Ass'n	Farmersville, O., As — F
Jefferson Ins. Co. of New York	New York, N. Y., S — FC
Jefferson Nat'l Life. Ins. Co. (*)	Indianapolis, Ind., S — L
Jefferson Standard Life Ins. Co	Greensboro, N. C., S — L
Jersey Ins. Co. of N. Y. (s)	New York, N. Y., S — FC
Jewelers Mut. Ins. Co	Neenah, Wis., M — F
John Hancock Mut. Life Ins. Co. (*)	Boston, Mass., M — L

Company Name	Corporate Address & Classification

(K)

Kansas City Fire & Marine Ins. Co. (s)	Kansas City Mo., S — FC
Kansas City Life Ins. Co	Kansas City, Mo., S — L
Kansas City Title Ins. Co	Kansas City, Mo., S — T
Kemba Mut. Ins. Ass'n	Cincinnati, O., As — S
Kentucky Central Ins. Co	LEXINGTON ~~Anchorage~~, Ky., S — F
Kentucky Central Life Ins. Co. (*)	Lexington, Ky., S — L
Kentucky Home Mut. Life Ins. Co. (*)	Louisville, Ky., M — L
Knights of Columbus	New Haven, Conn., Fra — FL

(L)

Ladies' Catholic Benevolent Ass'n	Erie, Pa., Fra — FL
Ladies' Pa. Slovak Catholic Union	Wilkes-Barre, Pa., Fra — FL
Lafayette Life Ins. Co. (*)	Lafayette, Ind., M — L
Lake Mut. Ins. Co., The	Uniontown, O., As — F
Lawyers Title Ins. Corp	Richmond, Va., S — T
Laymen Life Ins. Co	Anderson, Ind., S — L
Liberty Mut. Fire Ins. Co. (s)	Boston, Mass., M — FC
Liberty Mut. Ins. Co. (s)	Boston, Mass., M — FC
Life & Cas. Ins. Co. of Tenn. (*)	Nashville, Tenn., S — L
Life Assur. Co. of Pa. (*)	Philadelphia, Pa., S — L
Life Ins. Co. of N. A. (*)	Philadelphia, Pa., S — L
Life Ins. Co. of Va., The (*)	Richmond, Va., S — L
Lifeco Ins. Co. of Am. (*)	Seattle, Wash., S — L
Lightning Rod Mut. Ins. Co	Wooster, O., M — FC
Lime City Farmers' Mut. Fire Ins. Ass'n	Perrysburg, O., As — F
Lincoln Nat'l Life Ins. Co., The (*)	Ft. Wayne, Ind., S — L
Lithuanian Alliance of A	Wilkes-Barre, Pa., Fra — FL
Lithuanian Roman Catholic Alliance of A	Wilkes-Barre, Pa., Fra — FL
Lititz Mut. Ins. Co	Lititz, Pa., M — FC
Liverpool & London & Globe Ins. Co., Ltd., The (s)	Liverpool, Eng., S — FC
U. S. Address	New York, N. Y.
Locomotive Engineers Mut. Life & Acc. Ins. Ass'n, The	Cleveland, O., Fra — FL
London Assurance, The (s)	London, Eng., S — FC
U. S. Address	New York, N. Y.
London Guarantee & Acc. Co., Ltd. (s)	London, Eng., S — FC
U. S. Address	New York, N. Y.
London & Lancashire Ins. Co., Ltd., The (s)	London, Eng., S — FC
U. S. Address	New York, N. Y.
Lordstown Farmers' Mut. Ins. (Fire) Co., The	Lordstown, O., As — F
Louisville Title Ins. Co	Louisville, Ky., S — T
Loyal Protective Life Ins. Co. (*)	Boston, Mass., S — L
Lucas County Mut. Ins. Ass'n	Swanton, O., As — F
Lumber Mut. Fire Ins. Co. of Boston, Mass., The	Boston, Mass., M — FC
Lumbermens Mut. Cas. Co. (s)	Chicago, Ill., M — FC
Lumbermens Mut. Ins. Co., The (S)	Mansfield, O., M — FC
Lumbermens Underwriting Alliance, U. S. Epperson Underwriting Co., Att'y-in-Fact	Kansas City, Mo., R — F

Company Name	Corporate Address & Classification
Lutheran Brotherhood	Minneapolis, Minn., Fra — FL
Lutheran Mut. Life Ins. Co.	Waverly, Ia., M — L
Lynn Mut. [redacted] Ins. Co.	Concord, Mass., M — FC

(M)

Maccabees Mut. Life Ins. Co. (*)	Southfield, Mich., M — L
Madison Mut. Ins. Co., The	Arlington, O., As — F
Mahoning Ins. Co.	Youngstown, O., S — FC
~~Maine Bonding & Cas. Co. (s)~~ 12-31-63	~~Portland, Me., S — FC~~
Mammoth Life & Acc. Ins. Co. (*)	Louisville, Ky., S — L
Manchester Ins. & Ind. Co.	Cincinnati, O., S — FC
Manhattan Fire & Marine Ins. Co., The (s)	New York, N. Y., S — FC
Manhattan Life Ins. Co. (*)	New York, N. Y., M — L
Manufacturers Life Ins. Co.	Toronto, Canada, S — L
Manufacturers Mut. Fire Ins. Co.	Providence, R. I., M — FC
Marine Ins. Co., Ltd., The (s)	London, Eng., S — FC
U. S. Address	New York, N. Y.
Marion Mut. Ins. Ass'n of Mercer County, Ohio, The	St. Rosa, O., As — F
Maritime Ins. Co., Ltd.	Liverpool, Eng., S — FC
U. S. Address	New York, N. Y.
Maryland Cas. Co. (s)	Baltimore, Md., S — FC
Maryland Nat'l Ins. Co. (s)	Bel Air, Md., S — FC
Mass. Bay Ins. Co.	Boston, Mass., S — FC
Mass. Cas. Ins. Co.	Boston, Mass., S — C
Mass. Ind. & Life Ins. Co. (*)	Boston, Mass., S — L
Mass. Mut. Life Ins. Co. (*)	Springfield, Mass., M — L
Mass. Protective Ass'n, Inc., The	Worcester, Mass., S — C
Mayflower Ins. Co., The (s)	Columbus, O., S — FC
Medical Foundation of Bellaire	Bellaire, O., H — C
Medical Ind. of A., Inc.	Columbus, O., S — C
Medical Mut. of Cleveland, Inc.	Cleveland, O., M — C
Medical Protective Co., The	Ft. Wayne, Ind., S — C
Mennonite Aid Plan, The	West Liberty, O., As — F
Mennonite Mut. Aid Soc. of Putnam, Allen & Hancock Counties, Ohio, The	Bluffton, O., As — F
Mennonite Mut. Ins. Ass'n, The	Orrville, O., As — F
Mercantile Ins. Co. of A., The (s)	New York, N. Y., S — FC
Merchants & Business Men's Mut. Ins. Co.	Harrisburg, Pa., M — FC
Merchants & Mfrs.' Mut. Ins. Co.	Mansfield, O., M — FC
Merchants Fire Assur. Corp. of N. Y. (s)	New York, N. Y., S — FC
Merchants Ind. Corp. of N. Y. (s)	New York, N. Y., S — FC
Merchants Property Ins. Co. of Ind., The	Indianapolis, Ind., S — FC
Meridian Mut. Ins. Co. (s)	Indianapolis, Ind., M — FC
Merrimack Mut. Fire Ins. Co. (s)	Andover, Mass., M — FC
Metropolitan Fire Assur. Co.	New York, N. Y., S — FC
Metropolitan Life Ins. Co. (*)	New York, N. Y., M — L
Miami Mut. Ins. Ass'n	Troy, O., As — F
Miami Twp. Farmers' Mut. Ins. Ass'n	Miamisburg, O., As — F
Michigan Life Ins. Co. (*)	Royal Oak, Mich., S — L
Michigan Millers Mut. Ins. Co. (s)	Lansing, Mich., M — FC
Michigan Mut. Liab. Co. (s)	Detroit, Mich., M — FC

Company Name	Corporate Address & Classification
Mid-Century Ins. Co. (s)	Los Angeles, Cal., S — FC
Middlesex Mut. Ins. Co.	Concord, Mass., M — FC
Midland Mut. Life Ins. Co., The (*)	Columbus, O., M — L
Midland National Ins. Co.	Chicago, Ill., S — FC
Mid-States Ins. Co.	Evanston, Ill., S — C
Midwest Life Ins. Co. of Lincoln, Nebr., The (*)	Lincoln, Nebr., S — L
Midwest Mut. Ins. Co.	Des Moines, Ia., M — C
Midwestern Ind. Co., The (s)	Cincinnati, O., S — FC
Midwestern Nat'l. Life Ins. Co. of O.	Cleveland, O., S — L
Midwestern United Life Ins. Co. (*)	Ft. Wayne, Ind., S — L
Mill Owners Mut. Ins. Co.	Des Moines, Ia., M — FC
Millers' Mut. Fire Ins. Co., The	Harrisburg, Pa., M — FC
Millers' Mut. Fire Ins. Co. of Tex., The (s)	Ft. Worth, Tex., M — FC
Millers' Mut. Ins. Ass'n of Ill. (s)	Alton, Ill., M — FC
Millers Nat'l Ins. Co. (s)	Chicago, Ill., M — FC
Milwaukee Ins. Co. of Milwaukee, Wis. (s)	Milwaukee, Wis., S — FC
Ministers Life and Casualty Union, The (*)	Minneapolis, Minn., M — L
Minnesota Mut. Life Ins. Co., The (*)	St. Paul, Minn., M — L
Modern Woodmen of A.	Rock Island, Ill., Fra — FL
Mohawk Mut. Ins. Co.	Portsmouth, O., M — F
Monarch Ins. Co. of O., The (s)	Columbus, O., S — FC
Monarch Life Ins. Co. (*)	Springfield, Mass., S — L
Monumental Life Ins. Co. (*)	Baltimore, Md., S — L
Morgan County Grangers' Mut. Ins. Co.	Malta, O., As — F
Mortgage Guaranty Ins. Corp. (s)	Milwaukee, Wis., S — C
Motor Club of Am. Ins. Co.	Newark, N. J., S — FC
Motorists Mut. Ins. Co. (s)	Columbus, O., M — FC
Motors Ins. Corp.	New York, N. Y., S — F
Munich Reins. Co. (s)	Munich, Germany, S — FC
U. S. Address	New York, N. Y.
Mut. Benefit Life Ins. Co., The (*)	Newark, N. J., M — L
Mut. Boiler & Machinery Ins. Co.	Waltham, Mass., M — FC
Mut. Fire Ins. Co. of Eagle Twp.	Rawson, O., As — F
Mut. Fire & Storm Ins. Co. of Jackson, Amanda & Delaware Twps., The	Mt. Blanchard, O., As — F
Mut. Ins. Co. of Richland Twp., Marion County, O., The	Marion, O., As — F
Mut. Life Ins. Co. of N. Y., The (*)	New York, N. Y., M — L
Mut. of Omaha Ins. Co. (*)	Omaha, Nebr., M — L
Mut. Protective Ins. Co.	Omaha, Nebr., M — C
Mut. Trust Life Ins. Co.	Chicago, Ill., M — L

(N)

Nat'l Acc. & Health Ins. Co. of Philadelphia (*)	Philadelphia, Pa., S — L
Nat'l-Ben Franklin Ins. Co. of Pittsburgh, Pa. (s)	Pittsburgh, Pa., S — FC
Nat'l Cas. Co. (s)	Detroit, Mich., S — C
Nat'l Council of the Jr. Order of United American Mechanics of the U. S. of N. A.	Philadelphia, Pa., Fra — FL
Nat'l Fire Ins. Co. of Hartford (s)	Hartford, Conn., S — FC
Nat'l Fraternal Soc. of the Deaf	Oak Park, Ill., Fra — FL

Company Name	Corporate Address & Classification
Nat'l Grange Mut. Ins. Co. (s)	Keene, N. H., M — FC
Nat'l Guardian Life Ins. Co	Madison, Wis., M — L
Nat'l Home Life Assur. Co. (*)	St. Louis, Mo., S — L
Nat'l Ind. Co	Omaha, Nebr., S — FC
Nat'l Ins. Underwriters, Nat'l Aviation Underwriters, Inc Att'y-in-Fact	St. Louis, Mo., R — C
Nat'l Life & Acc. Ins. Co., The (*)	Nashville, Tenn., S — L
Nat'l Life Assur. Co. of Canada (*)	Toronto, Canada, S — L
Nat'l Life Ins. Co	Montpelier, Vt., M — L
Nat'l Masonic Provident Ass'n (*)	Mansfield, O., M — L
Nat'l Mut. Ins. Co., The	Celina, O., M — FC
Nat'l Old Line Ins. Co. (*)	Little Rock, Ark., S — L
Nat'l Slovak Soc. of the U. S. of A.	Pittsburgh, Pa., Fra — FL
Nat'l Surety Corp. (s)	New York, N. Y., S — FC
Nat'l. Travelers Life Co. (*)	Des Moines, Ia., M — L
Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. (s)	Pittsburgh, Pa., S — FC
Nat'l Union Ind. Co. (s)	Pittsburgh, Pa., S — FC
Nationwide Gen'l Ins. Co	Columbus, O., S — FC
Nationwide Life Ins. Co. (*)	Columbus, O., S — L
Nationwide Mut. Fire Ins. Co. (s)	Columbus, O., M — FC
Nationwide Mut. Ins. Co. (s)	Columbus, O., M — FC
Netherlands Ins. Co., The	The Hague, Holland, S — FC
U. S. Address	Keene, N. H.
New Amsterdam Cas. Co. (s)	New York, N. Y., S — FC
Newark Ins. Co. (s) (Holland Twp.)	Milford, N. J., S — FC
~~New England Ins. Co., (s)~~ 12-31-63	~~Springfield, Mass., S — FC~~
New England Mut. Life Ins. Co. (*)	Boston, Mass., M — L
New Hampshire Ins. Co. (s)	Manchester, N. H., S — FC
New Rotterdam Ins. Co	Rotterdam, The Netherlands, S — F
U. S. Address	New York, N. Y.
Newspaper Readers Acc. Ins. Ass'n	Columbus, O., As — A
New York Central Mut. Fire Ins. Co. (s)	Edmeston, N. Y., M — FC
New York Fire Ins. Co	New York, N. Y., S — FC
New York Life Ins. Co. (*)	New York, N. Y., M — L
New York Underwriters Ins. Co. (s)	New York, N. Y., S — FC
Niagara Fire Ins. Co. (s)	New York, N. Y., S — FC
Norfolk & Dedham Mut. Fire Ins. Co	Dedham, Mass., M — FC
North American Co. for Life, Acc. & Health Ins., The (*)	Chicago, Ill., S — L
North American Equitable Life Assur. Co. (*)	Columbus, O., S — L
North American Life Assur. Co. (*)	Toronto, Canada, M — L
North American Life Ins. Co. of Chicago (*)	Chicago, Ill., S — L
North American Life & Cas. Co. (*)	Minneapolis, Minn., S — L
North American Reassur. Co. (*)	New York, N. Y., S — L
North American Reins. Corp. (s)	New York, N. Y., S — FC
North American Swiss Alliance, The	Cleveland, O., Fra — FL
North American Union Life Assur. Soc	Chicago, Ill., Fra — FL
~~North British & Mercantile Ins. Co., Ltd.~~ 12-31-63	~~London, Eng., S — FC~~
~~U. S. Address~~	~~New York, N. Y.~~
North River Ins. Co., The (s)	New York, N. Y., S — FC
Northeastern Ins. Co. of Hartford (s)	Hartford, Conn., S — FC
Northeastern Life Ins. Co. of N. Y. (*)	New York, N.Y., S — L

Company Name	Corporate Address & Classification
Northern Assur. Co. of Am., The (s)	Boston, Mass., S — FC
Northern Ins. Co. of N. Y. (s)	New York, N. Y., S — FC
Northern Life Ins. Co. (*)	Seattle, Wash., S — L
Northland Ins. Co	St. Paul, Minn., S — FC
Northwestern Mut. Ins. Co. (s)	Seattle, Wash., M — FC
Northwestern Mut. Life Ins. Co	Milwaukee, Wis., M — L
Northwestern Nat'l Cas. Co	Wilmington, Del., S — C
Northwestern Nat'l Ins. Co. (s)	Milwaukee, Wis., S — FC
Northwestern Nat'l Life Ins. Co. (*)	Minneapolis, Minn., S — L
Northwestern Ohio Mut. Associated Ins., The	West Unity, O., As — F
Northwestern Security Ins. Co. (s)	Seattle, Wash., S — FC
Norton Mut. Fire Ass'n	Barberton, O., As — F

(O)

Occidental Life Ins. Co. of Cal. (*)	Los Angeles, Cal., S — L
Ocean Marine Ins. Co., Ltd., The	London, Eng., S — F
U. S. Address	New York, N. Y.
Ohio Athletic Injury Mut. Ass'n	Columbus, O., M — C
Ohio Bar Title Ins. Co., The	Columbus, O., S — T
Ohio Cas. Ins. Co., The (s)	Hamilton, O., S — FC
Ohio Farmers Ins. Co. (s)	Leroy, O., S — FC
Ohio Grangers Mut. Ins. Co	Jefferson, O., As — F
Ohio Hardware Mut. Ins. Co., The	Mansfield, O., M — FC
Ohio Ind. Co	Dayton, O., S — FC
Ohio Ins. Ass'n	Bellville, O., As — F
Ohio Life Ins. Co	Hamilton, O., S — L
Ohio Medical Ind., Inc	Columbus, O., S — C
Ohio Mut. Ins. Ass'n., The	Bucyrus, O., As — F
Ohio Nat'l Life Ins. Co., The (*)	Cincinnati, O., M — L
Ohio Security Ins. Co. (s)	Hamilton, O., S — FC
Ohio State Grange Mut. Ins. Co	Newark, O., M — FC
Ohio State Life Ins. Co., The (*)	Columbus, O., S — L
Ohio Valley Ins. Co. (s)	Cleveland, O., S — FC
Old Colony Ins. Co. (s)	Boston, Mass., S — FC
Old Equity Life Ins. Co. (*)	Gary, Ind., S — L
Old Line Life Ins. Co. of A., The (*)	Milwaukee, Wis., S — L
Old Republic Ins. Co	Greensburg, Pa., S — FC
Old Republic Life Ins. Co. (*)	Chicago, Ill., S — L
Old Security Life Ins. Co. (*)	Kansas City, Mo., S — L
Olympic Ins. Co	Los Angeles, Cal., S — FC
Oregon Mut. Ins. Co	McMinnville, Ore., M — FC

(P)

Pacific Employers Ins. Co. (s)	Los Angeles, Cal., S — C
Pacific Fidelity Life Ins. Co. (*)	Los Angeles, Cal., S — L
Pacific Ind. Co. (s)	Los Angeles, Cal., S — FC
Pacific Ins. Co. of New York (s)	New York, N. Y., S — FC
Pacific Mut. Life Ins. Co. (*)	Los Angeles, Cal., M — L
~~Pacific Nat'l Ins. Co. (s)~~	~~San Francisco, Cal., S — FC~~
Pan-American Life Ins. Co. (*)	New Orleans, La., M — L

* Name Changed to:
Transamerica Ins. Co.

Company Name	Corporate Address & Classification
Pan-Western Life Ins. Co.	Columbus, O., S — L
Paris & Washington Twps. Home Ins. Co.	Paris, O., As — F
Paternelle Fire & Gen'l Ins. Co., Ltd., La	Paris, France, S — F
U. S. Address	New York, N. Y.
Patriot Life Ins. Co. (*)	New York, N. Y., S — L
Patrons' Buckeye Mut. Ins. Co.	Cumberland, O., As — F
Patrons' Mut. Ins. Ass'n of O., The	Bellefontaine, O., As — F
Patrons' Mut. Relief Ass'n, The	Bellville, O., As — F
Paul Revere Life Ins. Co., The (*)	Worcester, Mass., S — L
Pawtucket Mut. Ins. Co. (s)	Pawtucket, R. I., M — FC
~~Pearl Assur. Co., Ltd. (s)~~ 12-31-63	~~London, Eng., S — FC~~
~~U. S. Address~~	~~New York, N. Y.~~
Peerless Ins. Co. (s)	Keene, N. H., S — FC
Penn Mut. Fire Ins. Co.	West Chester, Pa., M — FC
Penn Mut. Life Ins. Co., The (*)	Philadelphia, Pa., M — L
Pennsylvania Gen'l. Ins. Co.	Philadelphia, Pa., S — FC
Pennsylvania Ins. Co., The (s)	Philadelphia, Pa., S — FC
Pennsylvania Life Ins. Co. (*)	Philadelphia, Pa., S — L
Pennsylvania Lumbermens Mut. Ins. Co. (s)	Philadelphia, Pa., M — FC
Pennsylvania Manufacturers' Ass'n Cas. Ins. Co. (s)	Philadelphia, Pa., S—C
Pennsylvania Manufacturers' Ass'n Fire Ins. Co.	Philadelphia, Pa., S — F
Pennsylvania Millers Mut. Ins. Co.	Wilkes-Barre, Pa., M — FC
Pennsylvania Nat'l. Mut. Cas. Ins. Co. (S)	Harrisburg, Pa., M — FC
Pennsylvania Slovak Catholic Union	Wilkes-Barre, Pa., Fra — FL
Peoples Home Life Ins. Co. of Ind.	Indianapolis, Ind., S — L
Peoples Life Ins. Co., Washington, D. C. (*)	Washington, D. C., S — L
Permanent Ins. Co.	Akron, O., S — FC
Perry County Mut. Fire Ins. Co., The	New Lexington, O., As — F
Philadelphia Life Ins. Co.	Philadelphia, Pa., S — L
Philadelphia Manufacturers Mut. Ins. Co.	Philadelphia, Pa., M — FC
Philadelphia-United Life Ins. Co. (*)	Philadelphia, Pa., S — L
Phoenix Assur. Co. of N. Y. (s)	New York, N. Y., S — FC
Phoenix Ins. Co., The (s)	Hartford, Conn., S — FC
Phoenix Mut. Life Ins. Co. (*)	Hartford, Conn., M — L
Pickaway County Farmers' Mut. Fire Ass'n, The	Ashville, O., As — F
Pike Mut. Ins. Co.	Canton, O., As — F
Pilot Life Ins. Co. (*)	Greensboro, N. C., S — L
Pioneer Co-Operative Fire Ins. Co. (Mut.)	Greenville, N.Y., M — FC
Pioneer Mut. Cas. Co. of O., The (s)	Columbus, O., M — FC
Planet Ins. Co.	Madison, Wis., S — FC
Plymouth Reins. Co. (S)	Boston, Mass., S — FC
Police & Firemen's Ins. Ass'n	Indianapolis, Ind., FRA — FL
Polish Ass'n of A., The	Milwaukee, Wis., Fra — FL
Polish Nat'l Alliance of the U. S. of N. A.	Chicago, Ill., Fra — FL
Polish Nat'l Union of A.	Scranton, Pa., Fra — FL
Polish Roman Catholic Union of A.	Chicago, Ill., Fra — FL
Polish Women's Alliance of A.	Chicago, Ill., Fra — FL
Potomac Ins. Co. (s)	Philadelphia, Pa., S — FC
Poulsen Ins. Co. of A., The (*)	Park Ridge, Ill., S — L
Preferred Mut. Ins. Co. (s)	New Berlin, N. Y., M — FC
Preferred Risk Mut. Ins. Co. (S)	Des Moines, Ia., M — FC
Premier Ins. Co.	San Francisco, Cal., S — FC

Company Name	Corporate Address & Classification
Presbyterian Ministers' Fund	Philadelphia, Pa., M — L
Progressive Cas. Ins. Co. (s)	Cleveland, O., S — C
Progressive Life Ins. Co. (*)	Red Bank, N. J., M — L
Progressive Mut. Ins. Co. (s)	Cleveland, O., M — FC
Protected Home Circle	Sharon, Pa., Fra — FL
Protection Mut. Ins. Co.	Park Ridge, Ill., M — FC
Protective Ins. Co.	Indianapolis, Ind., S — C
Protective Nat'l. Ins. Co.	Omaha, Neb., S — C
Providence Washington Ins. Co. (s)	Providence, R. I., S — FC
Provident Ind. Life Ins. Co. (*)	Norristown, Pa., S — L
Provident Ins. Co. of N. Y. (s)	New York, N. Y., S — FC
Provident Life & Acc. Ins. Co. (*)	Chattanooga, Tenn., S — L
Provident Life & Cas. Ins. Co. (*)	Chattanooga, Tenn., S — L
Provident Mut. Life Ins. Co. of Philadelphia (*)	Philadelphia, Pa., M — L
Prudent American Life Assur. Co	Cleveland, O., S — L
Prudential Ins. Co. of A., The (*)	Newark, N. J., M — L
Prudential Ins. Co. of G. B. Located in N. Y. (s)	New York, N. Y., S — FC
Puritan Life Ins. Co. (*)	Providence, R. I., S — L
Putnam County Farmers' Mut. Ins. Co	Ottawa, O., As — F

(Q)

Quaker City Ins. Co	Philadelphia, Pa., S — FC
~~Quaker City Life Ins. Co. (*)~~ 3-16-64	~~Philadelphia, Pa., S — L~~
Queen Ins. Co. of A. (s)	New York, N. Y., S — FC
Quincy Mut. Fire Ins. Co	Quincy, Mass., M — FC

(R)

Reciprocal Exchange, Bruce Dodson, Att'y-in-Fact	Kansas City, Mo., R — F
Reins. Corp. of N. Y., The (s)	New York, N. Y., S — FC
Reliable Ins. Co., (s) CELINA	~~Dayton~~, O., S — FC
Reliance Ins. Co. (s)	Philadelphia, Pa., S — FC
Reliance Marine Ins. Co., Ltd.	Liverpool, Eng., S — FC
U. S. Address	New York, N. Y.
Republic-Franklin Ins. Co. (s)	Columbus, O., S — FC
Republic-Franklin Life Ins. Co. (*)	Columbus, O., S — L
Republic Ins. Co. (s)	Dallas, Tex., S — FC
Republic Mut. Fire Ins. Co	Kansas City, Kans., M — C
Republic Nat'l. Life Ins. Co. (*)	Dallas, Tex., S — L
Reserve Ins. Co. (s)	Chicago, Ill., S — FC
Reserve Life Ins. Co. (*)	Dallas, Tex., S — L
Resolute Credit Life Ins. Co. (*)	Providence, R. I., S — L
Resolute Ins. Co. (s)	Providence, R. I., S — FC
Richland Equity Mut. Ins. Ass'n of Shelby, O., The	Shelby, O., As — F
Richland-Knox Mut. Ins. Co.	Mansfield, O., M — FC
Richland Twp. Farmers' Mut. Ins. Ass'n	Bluffton, O., As — F
Richmond Farmers' Mut. Ins. Co., The	Richmond, O., As — F
Riverside Ins. Co. of A	Little Rock, Ark., S — FC
Rochdale Ins. Co.	New York, N. Y., S — FC
Royal Arcanum, Supreme Council of The	Boston, Mass., Fra — FL
Royal Clan, Order of Scottish Clans	St. Louis, Mo., Fra — FL

Company Name	Corporate Address & Classification
Royal Exchange Assur., The (s)	London, Eng., S — FC
U. S. Address	New York, N. Y.
Royal Ind. Co. (s)	New York, N. Y., S — FC
Royal Ins. Co., Ltd. (s)	Liverpool, Eng., S — FC
U. S. Address	New York, N. Y.
Royal League	Berwyn, Ill., Fra — FL
Royal Neighbors of A.	Rock Island, Ill., Fra — FL
Russian Brotherhood Organization of U. S. A.	Philadelphia, Pa., Fra — FL
Russian Orthodox Catholic Mut. Aid Soc. of U. S. A.	Wilkes-Barre, Pa., Fra — FL

(S)

Safeco Ins. Co., of A.	Seattle, Wash., S — FC
Safeguard Ins. Co. (s)	Hartford, Conn., S — FC
St. Louis Fire & Marine Ins. Co.	St. Louis, Mo., S — FC
St. Paul Fire & Marine Ins. Co. (s)	St. Paul, Minn., S — FC
St. Paul Mercury Ins. Co. (s)	St. Paul, Minn., S — FC
Sandy & Beaver Valley Farmers' Mut. Ins. Co.	Lisbon, O., As — F
Sea Ins. Co., Ltd., The (s)	Liverpool, Eng., S — FC
U. S. Address	New York, N. Y.
Seaboard Fire & Marine Ins. Co. (s)	New York, N. Y., S — FC
Seaboard Surety Co. (s)	New York, N. Y., S — FC
~~Secured Ins. Co. (s)~~ 6-1-64	~~Indianapolis, Ind., S — FC~~
Security Benefit Life Ins. Co. (*)	Topeka, Kans., M — L
Security-Connecticut Life Ins. Co. (*)	New Haven, Conn., S — L
Security Ins. Co. of New Haven (s)	New Haven, Conn., S — FC
Security Life & Acc. Co. (*)	Denver, Colo., S — L
Security Mut. Cas. Co. (s)	Chicago, Ill., M — FC
Security Mut. Life Ins. Co. of N. Y. (*)	Binghamton, N. Y., M — L
Security Nat'l Ins. Co.	Dallas, Tex., S — FC
Selective Ins. Co.	Cincinnati, O., S — FC
Sentry Life Ins. Co.	Stevens Point, Wis., S — L
Serb Nat'l Federation	Pittsburgh, Pa., Fra — FL
~~Serbian Beneficial Federation Unity~~ 8-16-63	~~Cleveland, O., Fra — FL~~
Service Cas. Co. of N. Y.	New York, N. Y., S — C
Service Fire Ins. Co. of N. Y.	New York, N. Y., S — F
Service Life Ins. Co. (*) OF OMAHA	Omaha, Nebr., S — L
Shelby County Farmers' Mut. Ins. Ass'n	Anna, O., As — F
Shelby Mut. Ins. Co. of Shelby, O., The (s)	Shelby, O., M — FC
Shenandoah Life Ins. Co. (*)	Roanoke, Va., M — L
Skandia Ins. Co.	Stockholm, Sweden, S — F
U. S. Address	New York, N. Y.
Skandinavia Ins. Co., Ltd.	Copenhagen, Denmark, S — F
U. S. Address	Tarrytown, N. Y.
Slovak Catholic Sokol	Passaic, N. J., Fra — FL
Slovak Gymnastic Union Sokol of U. S. A.	Perth Amboy, N. J., Fra — FL
Slovene Nat'l Benefit Soc.	Chicago, Ill., Fra — FL
Slovenian Mut. Benefit Ass'n	Cleveland, O., Fra — FL
Sonnenberg Mut. Ins. Ass'n	Dalton, O., As — F
Sons of Italy in A., Inc., Grand Lodge of O., Order of	Cleveland, O., Fra — FL

Company Name	Corporate Address & Classification
South Carolina Ins. Co. (s)	Columbia, S. C., S — FC
~~Southern Home Ins. Co.~~ 12-31-63	~~Greer, S. C., S — FC~~
Southwest Ind. & Life Ins. Co. (*)	Dallas, Tex., S — L
~~Springfield Ins. Co. (s)~~ 12-31-64	~~Springfield, Mass., S — FC~~
Springfield Twp. Mut. Ins. Ass'n	New Springfield, O., As — F
~~Standard Acc. Ins. Co. (s)~~ 12-31-64	~~Detroit, Mich., S — FC~~
Standard Fire Ins. Co., The (s)	Hartford, Conn., S — FC
Standard Life & Acc. Ins. Co. (*)	Oklahoma City, Okla., S — L
Standard Life Ass'n, The	Lawrence, Kans., Fra — FL
Standard Life Ins. Co. of Indiana (*)	Indianapolis, Ind., S — L
Standard Marine Ins. Co., Ltd.	Liverpool, Eng., S — FC
U. S. Address	New York, N. Y.
State Automobile Mut. Ins. Co. (s)	Columbus, O., M — FC
State Farm Fire & Cas. Co. (s)	Bloomington, Ill., S — FC
State Farm Gen'l Ins. Co.	Bloomington, Ill., S — FC
State Farm Life Ins. Co.	Bloomington, Ill., S — L
State Farm Mut. Automobile Ins. Co.	Bloomington, Ill., M — FC
State Life Ins. Co., The	Indianapolis, Ind., M — L
State Mut. Fire Ins. Ass'n, The	Lima, O., As — F
State Mut. Life Assur. Co. of A. (*)	Worcester, Mass., M — L
State Nat'l. Life Ins. Co. (*)	St. Louis, Mo., S — L
Steel Ins. Co. of Am., The	Chicago, Ill., S — F
Stuyvesant Ins. Co., The (s)	New York, N. Y., S — FC
Stuyvesant Life Ins. Co. (*)	Allentown, Pa., S — L
Summit Fidelity & Sur. Co., The (s)	Columbus, O., S — C
Sun Ins. Co. of N. Y. (s)	New York, N. Y., S — FC
Sun Ins. Office, Ltd.	London, Eng., S — FC
U. S. Address	New York, N. Y.
Sun Life Assur. Co. of Canada (*)	Montreal, Canada, S — L
Sun Life Ins. Co. of A. (*)	Baltimore, Md., S — L
Superior Ins. Co.	Dallas, Tex., S — FC
Superior Life Ins. Co. (*)	Philadelphia, Pa., S — L
Superior Risk Ins. Co. (s)	LeRoy, O. S — FC
Supreme Camp of the American Woodmen, The	Denver, Colo., Fra — FL
Supreme Forest, Woodmen Circle	Omaha, Nebr., Fra — FL
Supreme Life Ins. Co. of A. (*)	Chicago, Ill., S — L
Sutton & Chester Farmers' Mut. Fire Ins. Co.	Racine, O., As — F
Swiss Nat'l Ins. Co., U.S.A.	~~Miami, Fla.~~ Basle, Switz., S — F
~~U. S. Address~~	~~Miami, Fla.~~
Swiss Reins. Co. (s)	Zurich, Switz., S — FC
U. S. Address	New York, N. Y.
Switzer Mut. Fire Ins. Co.	Switzer, O., As — F
"Switzerland" Gen'l Ins. Co., Ltd.	Zurich, Switz., S — FC
U. S. Address	New York, N. Y.

(T)

Teachers Protective Mut. Life Ins. Co. (*)	Lancaster, Pa., M — L
Thames & Mersey Marine Ins. Co., Ltd.	Liverpool, Eng., S — F
U. S. Address	New York, N. Y.
Thomas Jefferson Ins. Co.	Louisville, Ky., S — F
Time Ins. Co. (*)	Milwaukee, Wis., S — L

Company Name	Corporate Address & Classification
Title Guarantee Co., The	Baltimore, Md., S — T
Title Ins. Co. of Minn.	Minneapolis, Minn., S — T
Toledo Health & Retiree Center, Inc., The	Toledo, O., H — C
~~Transamerica Ins. Co. (s)~~	~~San Francisco, Cal., S — F~~
Transatlantic Reins. Co. (s)	New York, N. Y., S — FC
Transcontinental Ins. Co. (s)	New York, N. Y., S — FC
Transit Cas. Co. (s)	St. Louis, Mo., S — FC
Transnational Ins. Co.	Los Angeles, Cal., S — F
Transport Ind. Co. (s)	Los Angeles, Calif., S — FC
Transport Ins. Co. (s)	Dallas, Tex., S — FC
Transportation Ins. Co. (s)	Chicago, Ill., S — FC
Travelers Ind. Co., The (s)	Hartford, Conn., S — FC
Travelers Ins. Co., The (*)	Hartford, Conn., S — L
Travelers Protective Ass'n of A., The	St. Louis, Mo., Fra — FL
Tri-County Mut. Ins. Co	Malvern, O. As — F
Trinity Mut. Fire Ins. Ass'n	Toledo, O., As — F
Trinity Universal Ins. Co. (s)	Dallas, Tex., S — FC
Truck Ins. Exchange, Truck Underwriters Ass'n., Atty-in Fact (s)	Los Angeles, Cal., R — FC
Twin City Fire Ins. Co. (s)	Minneapolis, Minn., S — FC

(U)

Ukranian Nat'l Aid Ass'n of A	Pittsburgh, Pa., Fra — FL
Ukranian Nat'l Ass'n, Inc	Jersey City, N. J., Fra — FL
Ukranian Workingmen's Assn	Scranton, Pa., Fra — FL
Underwriters Ins. Co	Chicago, Ill., S — F
Unified Reserve Life Ins. Co. (*)	Indianapolis, Ind., S — L
Union Central Life Ins. Co., The (*)	Cincinnati, O., M — L
Union Ins. Soc. of Canton, Ltd	Victoria, Hong Kong, S — FC
U. S. Address	New York, N. Y.
Union Labor Life Ins. Co., The (*)	Baltimore, Md. S — L
Union & League of Romanian Societies of A., Inc., The	Cleveland, O., Fra — FL
Union Marine & Gen'l Ins. Co., Ltd	Liverpool, Eng., S — FC
U. S. Address	New York, N.Y.
Union Mut. Ins. Co. of Providence	Providence, R. I., M — FC
Union Mut. Life Ins. Co. (*)	Portland, Me., M — L
Union & Phenix Espanol Ins. Co. (s)	Madrid, Spain., S — FC
U. S. Address	New York, N. Y.
Union of Poles in A., The	Cleveland, O., Fra — FL
Union Reins. Co. of Zurich, Switz. (s)	Zurich, Switz., S — FC
U. S. Address	New York, N. Y.
Union Security Life Ins. Co. (*)	Atlanta, Ga., S — L
Union Trust Life Ins. Co. (*)	Duluth, Minn., S — L
United American Ins. Co. (*)	Dallas, Tex., S — L
United Benefit Fire Ins. Co. (s)	Omaha, Nebr., S — FC
United Benefit Life Ins. Co. (*)	Omaha, Nebr., S — L
United Bonding Ins. Co. (s)	Indianapolis, Ind., S — C
United Commercial Travelers of A., The Order of	Columbus, O., Fra — FL
United Fire Ins. Co	New York, N. Y., S — F
United Home Life Ins. Co	Indianapolis, Ind., S — L

* Name Changed to:
Transamerica Ins. Co.

Company Name	Corporate Address & Classification
United Home Mut. Ins. Co., The	Bucyrus, O., M — FC
United Ins. Co. of A. (*)	Chicago, Ill., S — L
United Liberty Life Ins. Co. (*)	Dallas, Tex., S — L
United Life & Acc. Ins. Co. (*)	Concord, N. H., S — L
United Lutheran Soc.	Pittsburgh, Pa., Fra — FL
United Mut. Ins. Co. of Hancock County	Jenera, O., As — F
United Pacific Ins. Co. (s)	Tacoma, Wash., S — C
United Russian Orthodox Brotherhood of A.	Pittsburgh, Pa., Fra — FL
United Security Ins. Co.	Holland Twp., N. J., S — FC
United Security Life Co.	Des Moines, Ia., S — L
United Services Life Ins. Co.	Washington, D. C., S — L
United Societies of U. S. A.	McKeesport, Pa., Fra — FL
~~U.S.M. Life & Acc. Ins. Co. (*)~~	~~Cincinnati, O., S — L~~
U. S. Mut. Benefit Ass'n, The	MANSFIELD ~~Cincinnati~~, O., M — FC
United States Cas. Co. (s)	New York, N. Y., S — FC
United States Fid. & Guaranty Co. (s)	Baltimore, Md., S — FC
United States Fire Ins. Co. (s)	New York, N. Y., S — FC
United States Letter Carriers' Mut. Benefit Ass'n of the Nat'l Ass'n of Letter Carriers	Nashville, Tenn., Fra — FL
United States Life Ins. Co. in the City of N. Y., The (*)	New York, N. Y., S — L
Unity Fire & Gen'l Ins. Co., The (s)	New York, N. Y., S — FC
Unity Mut. Life Ins. Co. of New York (*)	Syracuse, N. Y., M — L
Unity of Czech Ladies & Men	Cicero, Ill., Fra — FL
Universal Ins. Co.	Flemington, N. J., S — F
Universal Surety Co. (s)	Lincoln, Nebr., S — FC
Universal Underwriters, Lynn Underwriting Co., Att'y-in-fact	Kansas City, Mo., R — F
Universal Underwriters Ins. Co.	Kansas City, Mo., S — FC
University Life Ins. Co. of A. (*)	Indianapolis, Ind., S — L
Urbaine Fire Ins. Co. (s)	Paris, France, S — FC
U. S. Address	New York, N. Y.
Utah Home Fire Ins. Co.	Salt Lake City, Utah, S — FC
Utica Fire Ins. Co. of Oneida County, N. Y. (Mut.) (s)	Utica, N. Y., M — FC
Utica Mut. Ins. Co. (s)	Utica, N. Y., M — FC

(V)

Valley Forge Ins. Co. (s)	Reading, Pa., S — FC
Valley Forge Life Ins. Co. (*)	Reading, Pa., S — L
Vanguard Ins. Co.	Dallas, Tex., S — FC
Variable Annuity Life Ins. Co. of A.	Washington, D. C., S — L
Vehicle Ins. Exchange, Vehicle Underwriting Co., Att'y-in-Fact	Cincinnati, O., R — F
Vico Ins. Co.	Little Rock, Ark., S — FC
Victory Mut. Life Ins. Co. (*)	Chicago, Ill., M — L
Vigilant Ins. Co. (s)	New York, N. Y., S — FC
Virginia Surety Co., Inc.	Roanoke, Va., S — FC
Volunteer State Life Ins. Co. (*)	Chattanooga, Tenn., S — L

* Name Changed to:
U. S. Assurance Co.

Company Name	Corporate Address & Classification
(W)	
Wabash Fire & Cas. Ins. Co. (s)	Indianapolis, Ind., S — FC
Warner Reciprocal Insurers, Lansing B. Warner, Inc., Att'y-in-fact	Chicago, Ill., R — F
Washington County Farmers' Mut. Ins. Ass'n	Marietta, O., As — F
Washington Fire & Marine Ins. Co	St. Louis, Mo., S — FC
Washington Gen'l Ins. Corp	New York, N. Y., S — FC
Washington Nat'l Ins. Co. (*)	Evanston, Ill., S — L
Washington Mut. Ins. Ass'n	Lakeville, O., As — F
Wayne Mut. Ins. Co	Wooster, O., M — FC
West American Ins. Co. (s)	Los Angeles, Cal., S — FC
West & Knox Township Farmers' Aid Soc	Minerva, O., As — F
West Virginia Life Ins. Co. (*)	Huntington, W. Va., S — L
Westchester Fire Ins. Co. (s)	New York, N. Y., S — FC
Western Bohemian Fraternal Ass'n	Cedar Rapids, Ia., Fra — FL
Western Cas. & Sur. Co. (s)	Ft. Scott, Kans., S — FC
Western Fire Ins. Co., The (s)	Ft. Scott, Kansas., S — FC
Western Life Ins. Co. (*)	St. Paul, Minn., S — L
Western Reserve Life Assur. Co. of O	Cleveland, O., S — L
Western Reserve Mut. Cas. Co., The (S)	Wooster, O., M — FC
Western Security Life Ins. Co. (*)	Oklahoma City, Okla., S — L
Western Slavonic Ass'n	Denver, Colo., Fra — FL
Western & Southern Life Ins. Co., The (*)	Cincinnati, O., M — L
Western Surety Co. (s)	Sioux Falls, S. D., S — C
Western World Life Ins. Co. (*)	Phoenix, Ariz., S — L
William Penn Fraternal Ass'n	Pittsburgh, Pa., Fra — FL
Wisconsin Life Ins. Co., The (*)	Madison, Wis., M — L
Wisconsin Nat'l. Life Ins. Co. (*)	Oshkosh, Wis., S — L
Wolverine Ins. Co. (s)	Battle Creek, Mich., S — FC
Woman's Benefit Ass'n	Port Huron, Mich., Fra — FL
Women's Catholic Order of Foresters	Chicago, Ill., Fra — FL
Wood County Farmers' Mut. Fire Ass'n	Bowling Green, O., As — F
Woodmen Acc. & Life Co. (*)	Lincoln, Nebr., M — L
Woodmen of the World Life Ins. Soc	Omaha, Nebr., Fra — FL
Woodville Mut	Woodville, O., As — F
Worcester Mut. Fire Ins. Co. (s)	Worcester, Mass., M — FC
Workmen's Benefit Fund of the U. S. of A., Inc	Brooklyn, N. Y., Fra — FL
Workmen's Circle, The	New York, N. Y., Fra — FL
World Ins. Co. (*)	Omaha, Nebr., M — L
(Y)	
Yorkshire Ins. Co. of N. Y., The (s)	New York, N. Y., S — FC
(Z)	
Zivena Beneficial Soc	Pittsburgh, Pa., Fra — FL
Zurich American Life Ins. Co	Chicago, Ill., S — L
Zurich Ins. Co	Zurich, Switz., S — FC
U. S. Address	Chicago, Ill.
Zurich Life Ins. Co. (*)	New York, N. Y., S — L

SUMMARY

	OHIO	FOREIGN	ALIEN	TOTAL
Fire and Casualty Companies				
Assessment	88	——	—	88
Mutual	30	95	—	125
Reciprocal	3	12	—	15
Stock	31	290	45	366
Fraternal Societies	21	75	1	97
Health Care Corporation	2	——	—	2
Hospitalization Associations	8	——	—	8
Life Companies				
Mutual	6	73	1	80
Stock	19	153	8	180
Assessment Accident	4	——	—	4
Title	1	12	—	13
Total	213	710	55	978

BEWARE OF BOOTLEG INSURANCE

Oklahomans are being warned by Joe B. Hunt, State insurance commissioner, that they should not buy insurance from unlicensed companies that are bootlegging business into the State of Oklahoma through the mails and through various advertising media.

These unlicensed companies do not pay premium taxes and fees to the State of Oklahoma nor have their policy forms been approved by the Oklahoma Insurance Commissioner.

Oklahomans purchasing insurance from unlicensed companies do not have the benefit and protection of the Okalahoma Insurance Code afforded to them through licensed insurance companies.

Oklahomans should buy their insurance from local hometown agents who sell through duly licensed companies.

When in doubt, write or contact Joe B. Hunt, State Insurance Commissioner, Will Rogers Memorial Office Building, Oklahoma City, Okla.

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