

Decision

IN THE MATTER OF
NATIONAL CASUALTY COMPANYORDER, ETC., IN REGARD TO THE ALLEGED VIOLATION OF THE
FEDERAL TRADE COMMISSION ACT*Docket 6311. Complaint, Mar. 11, 1955—Decision, May 21, 1956*

Order requiring an insurance company with main office at Detroit, Mich., selling policies through some 350 to 400 independent insurance agencies throughout the nation, to cease misrepresenting the duration, coverage, and benefits of its accident and health insurance policies, and the physical requirements for policyholders in printed brochures and advertising matter sent to agents for use in soliciting prospects.

Mr. J. W. Brookfield, Jr. and Mr. Donald K. King for the Commission.

Mr. John F. Langs, of Detroit, Mich., for respondent.

INITIAL DECISION BY FRANK HIER, HEARING EXAMINER

Complaint herein issued March 11, 1955, charging respondent with misrepresenting its accident and health policies by soliciting their sale through printed brochures and advertisements which stressed or mentioned only maximum benefits or coverage while omitting actual policy exclusions or limitations thereby deceiving or misleading prospects into purchasing policies not as extensive or secure as they believed, in violation of Section 5 of the Federal Trade Commission Act (Title 15, U.S.C.A. 45). Answer admitted descriptive facts alleged and denied misrepresentation, and jurisdiction to proceed.

On the issues joined two hearings were held to complete proponent's proof, at the close of which respondent's counsel moved to dismiss the complaint for lack of jurisdiction and insufficient proof to constitute a prima facie case. The jurisdictional attack was two-pronged and founded on the language of so-called Public Law 15, 79th Congress (Title 15, U.S.C.A. 1011-15). The contentions were that since respondent is a Michigan corporation and Michigan by statute expressly prohibits the acts alleged in the complaint there was none of respondent's business that was not "regulated by State law," and that even if the Michigan statute be held to have no extraterritorial regulation that, nevertheless, respondent's business was fully regulated by the separate law of each state where it does business. The first contention was denied substantively, the second solely because at least one state where respondent does business, Mississippi, admittedly has no regulation whatever. The second ground of the motion that no prima

Findings

52 F. T. C.

facie case had been shown was denied on the merits, and subsequently two additional hearings were held for the reception of respondent's evidence, proof taking was closed and proposed findings of fact and conclusions were submitted by all counsel, on consideration of which, with the rest of the record herein, the Hearing Examiner finds that this proceeding was brought in the public interest and makes the following:

FINDINGS AS TO THE FACTS

1. Respondent National Casualty Company is a corporation organized, existing and doing business under the laws of the State of Michigan with its office and principal place of business at 422 Majestic Building, Detroit 26, Michigan. It is a stock company incorporated for the purpose of selling accident, health, and all types of casualty insurance, being licensed to sell such policies in all States of the United States, the District of Columbia, and Hawaii, through resident agents located therein. The company does not sell life insurance and its casualty insurance is not involved in this proceeding. In 1953 respondent received premiums of \$15,519,025 and in 1954 premiums of \$16,208,154 on its accident and health policies.

2. Respondent uses the agency system of selling its insurance policies by solicitation from 350 to 400 direct but independent insurance agencies throughout the nation who operate under contract of the respondent on commission only, in nonexclusive territories, and for this purpose respondent prepares, sends and ships to these agents direct mailing cards, stuffers, one page lead sheets, form letters, applications with tear sheets and throw aways. The majority of this is shipped by mail to the agent in bulk for his use and dissemination. Something less than five percent of respondent's direct mail advertising is disseminated by respondent directly from its own offices in Detroit to members of the public on behalf of its agents, and at their request, to obtain leads from prospects. Generally, the company bears the expense of printing advertising prepared by it but the agent assumes the cost of dissemination. The record does not show exactly what printed material was mailed directly by respondent from Detroit to prospects, as hereinafter found in Paragraphs 9, 12, 15, 19, and 23. All it shows is that something less than five percent of respondent's business was done that way. For the purposes of this discussion therefore, it is assumed that some of those mailings were of the printed material hereinabove found to be misleading or deceptive.

3. Eighty percent or more of all respondent's accident and health policies are issued by it from its home office after receipt, checking, and consideration by it of the prospect's signed application which has

1385

Findings

been secured by the agent. Any policy issued by respondent is forwarded to the agent for delivery to the insured. A very small number of respondent's agents may issue policies directly but respondent's home office has subsequent veto power over them after consideration of the application and policy which have been forwarded to it by the issuing agent.

4. Respondent now maintains and for the past several years has maintained substantial course of trade in insurance policies in commerce as "commerce" is defined in the Federal Trade Commission Act between and among each of the States of the United States.

5. Premium collection is the agent's responsibility, only five percent or less being remitted directly to the respondent, and this because of unusual or temporary situations. Premium notice forms are printed by respondent and furnished free of charge to all agents who mail them out locally. Very few such notices are mailed by respondent directly.

6. To procure business, these agents mail locally respondent's direct mailing pieces to likely prospects, secure leads thereby and otherwise, then call and personally solicit the prospect, or they are distributed personally by the agent. Although respondent's advertising pieces exemplified in the record may be primarily for the agent's aid and benefit in his solicitation, there is no doubt that they are also shown in a substantial number of instances to prospects to induce purchase and with that effect. Respondent's agents may locally advertise also but only with prior approval by respondent's home office. The latter does not furnish leads to its agents except on rare occasions. Occasionally also, it will mail out advertising direct from Detroit at the request of some agent because of temporary or unusual circumstances which make it more feasible to do so than to have the mailing done by the agent. Respondent's renewal business is just as important to respondent as its new business.

7. The insurance commissioner of Michigan inspects respondent's acts, practices, and files about every four years but this inspection is primarily the accounting phase of respondent's business and respondent's officials do not know whether respondent's advertising is examined or not. Respondent's officials have nothing to show approval of respondent's advertising by the Michigan insurance commissioner. In any event it was never submitted to him for approval. Respondent does not submit its advertising to the insurance commissioner of the State of Michigan for approval before it is used. Respondent's business was not inspected by the insurance commissioner of the State of Michigan during the time covered by the complaint herein. By mutual agreement of counsel the years 1953 and 1954 are the period involved.

Findings

52 F. T. C.

8. To arouse interest in, and induce purchase of its insurance policies, respondent, in the manner indicated above has made numerous statements and representations in its advertising pieces. Those alleged to be false, deceptive or misleading by the complaint herein, fall roughly into five categories: (1) termination date; (2) physical condition; (3) complete coverage; (4) dollar amounts; (5) specific time covered.

9. Under the first category respondent has represented:

No increase in premium because of age.

No decrease in benefits because of age.

Lifetime accident benefits.

For employed men and women ages 16 to 69 years inclusive.

Life indemnity accident coverage.

For individuals or family groups—ages 1 day to 69 years.

Security plan with lifetime benefits.

I understand this peace of mind and security will be mine from the first day—even for life.

We have removed all age termination limits from the policy.

10. Some of these circulars were distributed by respondent directly or through its agents in all states and the District of Columbia. Respondent's officials testified that the statements set out in Paragraph 9 supra, are representations with respect to benefits, not duration; that they were used to differentiate respondent's policies from policies of other companies which have age limitations more narrow than respondent's and to overcome any impression of these narrower limits which might have been built up in the public mind by old advertising of others when the limitations were more narrow.

11. Whatever the intent, these statements can reasonably be expected to give a substantial number of readers the definite impression that the policy will continue in effect so long as premiums are paid at least until age 69, or even for life, with full indemnification. To those past 45 years particularly this is a most material and important consideration. The fact is that respondent's policies all provide that they may be terminated by respondent at its sole option at the end of any premium period. Two of these policies may be cancelled at any time by respondent. The finding is that the representations made are deceptive and misleading.

12. The second category of alleged misrepresentations involves the statement "no medical examination required" appearing in ten different circulars distributed by respondent in all states and the District of Columbia. It has been used by respondent for 14 years or more, and by accident and health companies for 20 years. Respondent adopted it because accident and health insurance has become widespread only in the last twenty-five years. In its early days, people

had the impression that because life companies required a preliminary medical examination, respondent would also. People "hesitated buying because they feared it might require a medical examination." "I think it has been (used) merely primarily, let us say, to convey to people that you could get this insurance without going through a lot of red tape."

13. The quoted statement is unqualified as to time, condition or circumstances. Yet respondent's policies all provide that no benefits will be paid for loss resulting from sickness, the cause of which is traceable to a condition existing prior to, or within 15 to 30 days after the effective date of the policy, and that "the company shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pending of any claim hereunder." Respondent's accident policies require that "the loss shall result directly and independently of all other causes" to show which, the insured may have to submit medical evidence, obtainable only by medical examination.

14. Medical examinations are a groundless fear to many people, especially those approaching or in middle age, when functional degenerations set in. They are a nuisance to others. To everyone, any statement about a medical examination is most material. It would have been a simple and inexpensive matter to have added the words "before issuance of the policy" to the quoted statement. The bare representation carries, in the Hearing Examiner's opinion, the definite impression that respondent insures without regard to the prospect's physical condition either before or after issuance of the policy. Such being not the fact the statement is definitely misleading and deceptive.

15. Under the third category in Paragraph 8 supra, respondent has represented that its policies provide:

The most complete and broadest coverage at the lowest rates.

Monthly benefits up to \$300.00 per month paid from first day of sickness or accident plus \$300.00 per month for hospitalization.

Hospital room and board for 100 days for each sickness or accident. Your choice of plans paying from \$5.00 to \$12.50 per day. Pays full benefit even if your hospital room costs less.

Guaranteed monthly income for sickness.

Guaranteed monthly income for accidents.

When I am sick \$600.00 a month as long as three months.

New modern all-inclusive hospital surgical nurse protection.

Occupational and non-occupational accidents fully covered.

Full coverage on or off the job.

Full coverage for female diseases.

You should be fully protected against these expenses.

16. The policies, to sell which, these representations were issued, contain exclusions and limitations which belie "most complete" or

Findings

52 F. T. C.

"broadest coverage," "fully protected," "first day of sickness," etc. This indemnity for sickness is payable only for one "which is contracted or begins after this policy has been in force not less than thirty days from its date." Preexisting illness as well as illness during the first thirty days of policy life is consequently excluded. Excluded also are sickness caused by venereal disease, injury resulting from air travel on other than a scheduled or common carrier, suicide or its attempt, selfinflicted injuries, diseases or accidents to the female organs, injuries or illness occurring outside the United States and Canada. Indemnity payments are limited (reduced benefits) when illness or accident is due to tuberculosis, paralysis, hernias, female disease or mental derangement. Some exclude benefits for sickness or accident covered by Workmen's Compensation Acts, others pay only proportional indemnity, if other insurance is carried. Sickness or accidental injury must wholly and continuously disable and prevent the insured from performing any and all duties pertaining to his or her occupation. Specified indemnities for loss of limb or eye provide for immediate and automatic termination of the policy upon payment thereof. In each instance, these exclusions, exceptions and limitations appear in some of respondent's policies, in some instances, in all of its policies exhibited in the record.

17. Advertising pieces containing the excerpts set out above were disseminated either by direct mail (something less than five percent) or shipped to agents and by them distributed in all states in some instances, in a number of states in other instances.

18. The discrepancies between promise and policy set out in Paragraphs 15 and 16 supra, are obviously material and in the opinion of the Hearing Examiner may well be reasonably expected to give a prospect an impression of wider and fuller coverage than he gets. To that extent they are deceptive and misleading.

19. In the category of "dollar amounts" respondent has represented in its advertising pieces, financial benefits for loss, as follows:

Surgical operations, whether performed in or out of the hospital, are paid up to \$300.00 in addition to hospital benefits. Full benefits are paid to all insured members of the family group.

Surgery bills from \$5.00 to \$300.00 for sickness or accident.

Pays surgical operation expenses \$300.00.

Surgical plan to \$300.00.

Three choices of surgical operation benefits; \$5.00 to \$150, \$7.50 to \$225.00. \$10.00 to \$300.00.

Your doctor's bills paid at home, at hospital, at doctor's office.

\$10.00-\$300.00 available surgical operation fees.

Pays surgical operation fees up to \$150.00.

Who pays these bills? You should be fully protected against all these expenses. Never before has such protection been offered.

1385

Findings

20. Through such statements, respondent has represented, among other things, that the policies to which they refer provide indemnity up to a maximum sum of \$300 for any operation serious enough to cost such an amount.

Respondent's policies do not so provide. Under the terms of the policies, payments on account of surgical operations are in accordance with a schedule of fixed fees for different types of operations. Of the numerous operations listed, varying with the different policies from forty-seven to ninety, only a very small number (ranging from two to six on the different schedules) call for payments of as much as \$150 or \$300 (depending on the amount of premium paid). By way of contrast, the operations for which payments of \$25.00 or less are provided, regardless of the actual cost to the policyholder, range from twenty-one in the case of one of the schedules to forty-three in the case of another. Furthermore, according to the terms of the policies, no payments will be made for tonsillectomy, adenoidectomy, appendectomy, herniotomy, hemorrhoidectomy, or for operations for any injury or disease of the female generative organs unless the policy shall have been in force for not less than six months from date of issue. None of these limitations or conditions is disclosed in the advertising.

21. Most of the representations set out in paragraph 19 were distributed in all states; others only in some states.

22. Respondent's representations referred to in paragraphs 19 and 20 have the tendency and capacity to mislead and deceive, and, in the absence of an accompanying schedule clearly disclosing the payments for which the policies provide, are false and deceptive.

23. The last category of alleged misrepresentations "specific time covered" are exemplified by the following:

Monthly income up to \$300.00 for total disability from sickness paid from first day for two years with no confinement required at any time.

Monthly income up to \$300.00 for total accident or confining sickness disability paid from first day for as long as disabled—even for life.

When you are disabled by accident or sickness—what do you need most?

CASH!

Economy Disability Policy

The simple economical way to obtain basic

Income Protection

Sound protection—low cost

For Accident income \$. per month

Accident

Total Disability—full monthly benefit for 12 months

Partial Disability— $\frac{1}{2}$ monthly benefit for one month

Findings

52 F. T. C.

For Sickness income \$. per month
Sickness

Confining total disability—full monthly benefit for six months

Non-confining total disability—full monthly benefit for one month

Your security—

If injured or sick

you are protected while at work or away from work—benefits paid in addition to compensation and group insurance—24 hour every day protection.

Guaranteed monthly income for accidents.

Guaranteed monthly income for sickness.

Monthly benefits up to \$300 per month paid from first day of any sickness or accident.

Sickness indemnity; total disability full monthly indemnity for two years.

24. These representations reasonably give the impression of indemnification in a specific amount for a definite period of time. "From the first day for two years," "From the first day as long as totally disabled—even for life," "Accident income \$. per month," etc., reasonably convey that impression.

25. Respondent's policies themselves, however, confer the indemnity promised only if the insured is wholly and continuously disabled by sickness and prevented thereby from performing any and every occupation or employment plus being under the personal attendance of a doctor. Obviously, there is much illness and disability which does not meet these requirements, especially during convalescence. Some of respondent's policies require continuous confinement to the house, before respondent will pay. Other exclusions are any indemnity for more than one month where loss is due to tuberculosis, hernia, paralysis, or mental derangement; no sickness which began before thirty days after policy issuance; disability arising more than 5, 20, or 30 days after the accident; maternity benefits only after policy has been in effect ten months—in other words, respondent gets ten months' premiums before it has to pay for loss of time for maternity. All of these exceptions, exclusions, and limitations, seem to the Hearing Examiner to be highly important to substantial segments of prospects, and unlikely to occur to them as exceptions. The representations reasonably give the impression of definite amounts for a definite time, and to that extent are misleading and deceptive.

26. All of these representations were distributed in a substantial number of states.

27. Respondent's executive vice-president, its director of agencies, its claims adjuster, and its general agent in Detroit, Michigan, all of whom had been in the accident and health insurance business for many years, all testified that they had never personally received any complaint from any insured or from any prospect as to being misled or deceived by any of respondent's representations; that no such com-

Findings

plaint had come to them officially through company channels; that no such complaint had ever been received from the insurance commissioner of any state; and that many of these representations had been used up to 20 years, all of them over a period of years. This, of course, is not conclusive. Deception may have occurred without resulting in written or formal complaint and there may have been complaints also to local agents which were not forwarded to respondent. Furthermore, this evidence at most goes only to show an absence of actual deception. Under many decided cases, actual deception is not essential, it is sufficient if there is a reasonable probability of deception. *Bockenstette v. F.T.C.*, 134 F. 2d 369, 371; *Empire Oil & Gas Corp. v. U.S.*, 136 F. 2d 868, 872; *Jacob Siegel Co. v. F.T.C.*, 150 F. 2d 751, 755. That respondent's advertising was used largely to distinguish its coverage from those of life companies, or those of other health and accident companies is immaterial, as if the fact that there was no deliberate intent to deceive. Intent is immaterial in this type of case. *F.T.C. v. Algoma Lumber Co., et al.*, 291 U.S. 67, 81.

28. Respondent also defends on the basis of abandonment or voluntary cessation. The record shows that respondent is a member of the Health and Accident Underwriters Conference, that a standing subcommittee on ethics and practices prepared a code of ethics for such insurance practice, including advertising, that such code was thereafter adopted by the executive committee of the conference in May 1954, of which executive committee, respondent's executive vice-president was then, and had been, for many years a member. The record further shows that thereafter respondent began to discard and discontinue such of its printed material as came within the condemnation of that code, although some of them are still in use. On that basis, respondent claims this proceeding to be moot and not in the public interest and moves dismissal.

29. Dismissal on this ground is discretionary with the Commission—it is not a matter of right, nor does it defeat jurisdiction. *Sears, Roebuck Co. v. F.T.C.*, 258 F. 307-10; *F.T.C. v. Standard Educational Society, et al.*, 86 F. 2d 692, 697; *National Silver Co. v. F.T.C.*, 88 F. 2d 425, 427; *Hershey Chocolate Corporation v. F.T.C.*, 121 F. 2d 968, 971; *Philip R. Park v. F.T.C.*, 136 F. 2d 428. The very fact that an industry committee saw in this printed material the reasonable probability that it might mislead, even though there had been no complaint thereof to respondent in 10-20 years, reinforces the examiner's opinion that, some of it, as above set out, does so. Respondent's discontinuance confirms this. There is nothing in the record to indicate it may not be resumed, in the same or dangerously similar form. The record shows that these "sales aids" are constantly undergoing

Conclusions

52 F. T. C.

change, revision, discontinuance, replacement with new ideas, etc. The public interest requires, it seems to this examiner, that it be made sure that it cannot be resumed in any manner.

30. The protection which this respondent sells, while not so vital as life insurance, is nevertheless as important to the insured as his income. An insurance policy is an intangible, incapable of sensory perception like furniture or clothing. It is a series of mental images, imperfectly conveyed by words. "One picture is worth a thousand words" or as Mr. Dooley described documents generally, decades ago—just a "mess of words." The sheer quantity of language in a policy is per se confusing to a layman. The pressure for conciseness and precision, produces plausibly plain but actually technical language. Expressions such as "due proof of loss;" "if any time limitation of this policy with respect to give notice of claim or furnishing proof of loss is less than that permitted by the law of the state;" "resulting from accidental bodily injury effected directly and independently of all other causes" have rather definite meanings to lawyers, underwriters, and claims adjusters but are not fully understood by laymen. As the Court said in *U.S. v. Sylvanus*, 192 F. 2d 96, "It goes without saying almost that it is extremely difficult for a layman to understand the terms and conditions of such policies as these * * *." Similar judicial comments are legion. Hence respondent's argument that its agents carry specimen policies when selling and sometimes, or always, show them to prospects, is of little merit. As the same Court said on this point "That the policy holders by reading their policies, might have ascertained the conditions and limitations contained therein would not alter the fact, that the policies had been misrepresented, nor would it absolve defendants from responsibility for having made and transmitted such misrepresentations." For these same reasons, the guardian of the public interest in preventing misrepresentation or even misapprehension must be more vigilant, more careful, and more stringent than in other cases of alleged misrepresentation.

CONCLUSIONS OF LAW

1. The Federal Trade Commission has jurisdiction over all of the respondent's acts and practices alleged in the complaint to be unlawful.
2. The public interest in the proceeding is clear and substantial.
3. The use by respondent of the statements and representations, found herein to be false and deceptive, with respect to the terms and conditions of its policies of insurance, and its failure to reveal the limitations of the coverage of said policies, have the tendency and capacity to mislead and deceive a substantial portion of the purchasing public into the erroneous and mistaken belief that said state-

1385

Order

ments and representations are true and to induce the purchase of said policies of insurance because of such erroneous and mistaken belief.

4. The aforesaid acts or practices of respondent as above set forth are all to the prejudice and injury of the public and constitute unfair and deceptive acts or practices within the intent and meaning of the Federal Trade Commission Act.

ORDER

It is ordered, That respondent, National Casualty Company, a corporation, and its officers, agents, representatives and employees, directly or through any corporate or other device, in connection with the offering for sale, sale and distribution in commerce, as "commerce" is defined in the Federal Trade Commission Act, of any accident, health, hospital or surgical insurance policy, do forthwith cease and desist from representing, directly or by implication:

1. That any such policy may be continued in effect by the insured upon payment of stipulated premiums, indefinitely or for any stated time, unless full disclosure of any other provision or condition of termination contained in the policy is made conspicuously, prominently, and in sufficiently close conjunction with the representation as will fully relieve it of all capacity to deceive.

2. That no medical examination is required, unless the respondent actually insures the policyholder without regard to his physical condition before or after issuance of the policy; or otherwise representing that the condition of the insured's health at the time of issuance of the policy will not be considered by the respondent in determining its liability thereunder, or that the respondent will not, as a claims practice, require proof of good health of the insured at the time of issuance of the policy.

3. That any policy provides for payment in full or in any specified amount or for payment up to any specified amount for any medical, surgical or hospital service, unless the policy provides that the actual cost to the insured for that service will be paid in all cases up to the amount represented, or unless full disclosure of the schedule of payments for which the policy provides is made conspicuously, prominently, and in sufficiently close conjunction with said representation as will fully relieve it of all capacity to deceive.

4. The extent or duration of either coverage or benefits payable under the terms of any policy, unless a statement of all the conditions, exceptions, restrictions and limitations affecting the indemnification actually provided is set forth conspicuously, prominently, and in sufficiently close conjunction with the representation as will fully relieve it of all capacity to deceive.

Opinion

52 F. T. C.

It is further ordered, That respondent, National Casualty Company, shall, within sixty (60) days after service upon it of this order file with the Commission a report in writing setting forth in detail the manner and form in which it has complied therewith.

OPINION OF THE COMMISSION

By SECREST, Commissioner:

This is a proceeding in which the respondent was charged with having misrepresented the coverage and benefits afforded by its health and accident insurance policies. After appropriate hearings, during which evidence in support of and in opposition to the charges was received and a number of motions to dismiss the complaint were denied, the hearing examiner filed his initial decision from which both counsel in support of the complaint and the respondent have appealed. Presented for review are the examiner's findings and conclusions both as to the extent of the Commission's jurisdiction over the respondent's advertising practices and as to the tendency and capacity of the representations involved to mislead and deceive.

The respondent, a Michigan corporation, is licensed to sell, and does sell, its health and accident insurance policies in all of the states of the United States and in the District of Columbia and Hawaii. It carries on its business through an agency system composed of some 350 to 400 agencies located in each of the several states, and the respondent prepares and sends to its agents, for dissemination to prospects, advertising material in the form of direct mail cards, stuffers, lead sheets, form letters, applications with tear sheets and throwaways. In addition, and at the request of its agents, the respondent disseminates something less than five percent of its direct mail advertising directly from its own offices in Detroit to members of the public located throughout the country. As a general rule, the company issues its policies from its home office after receipt of signed applications therefor which have been obtained and forwarded to it by the agents, and the policies, when issued, are mailed to the agents for delivery to the purchasers.

For the purpose of inducing the purchase of its insurance policies, the respondent, in the manner indicated, has made numerous statements and representations with respect to the coverage and benefits provided by the policies. The complaint alleged that certain of these were false and deceptive and that the dissemination thereof constituted a violation of the Federal Trade Commission Act. Grouping the challenged representations into five categories, the examiner found that those in four of the categories were deceptive and misleading, while those in the fifth were not. He held further, however, that the

Commission's jurisdiction extends only to the respondent's advertising disseminated by direct mail and to its transactions in Mississippi, Rhode Island, Missouri, Montana and the District of Columbia, and he restricted the operation of the order to cease and desist contained in his initial decision accordingly.

The basis of the hearing examiner's conclusion as to the Commission's limited jurisdiction is that Congress, in enacting the McCarran-Ferguson Act (Public Law 15, 79th Congress, 15 U.S.C.A. § 1011-15), gave to the states, if they chose to exercise it, full regulation of the insurance business in all its phases (except where such state regulation is, as a matter of law, impossible or clearly ineffective, such as control over the United States mails), and that each of the states other than those named fully regulates the business of insurance by legislative enactment, with the result that as to transactions in such states the Commission's jurisdiction has been withdrawn. On this question the Commission, on April 24, 1956, fully expressed itself in its decision in the matter of *The American Hospital and Life Insurance Company*, Docket No. 6237. The views there stated are equally applicable here, and for the reasons set forth in that decision the examiner's conclusions in this case on the jurisdictional question are rejected.

This leaves for consideration the examiner's decision on the merits. As stated in the initial decision, the respondent's advertising representations which were alleged to have been false and deceptive had to do with continuation of the policies, physical condition of the insureds, extent of coverage, dollar amounts payable for operations, and time periods for which monthly payments could be expected. As to all except those dealing with dollar amounts payable for operations, the examiner held that the representations have been misleading and deceptive. With respect to the representations concerning dollar amounts payable for operations, his holding was otherwise.

Contending that its advertising statements, when read in context, are literally true and, further, that evidence of actual deception is lacking, the respondent in support of its appeal relies principally on the arguments (1) that the questioned advertising was disseminated almost exclusively in states having laws regulating the business of insurance, and (2) that the use of certain of the other material has been abandoned pursuant to a code of advertising ethics adopted by the Health and Accident Underwriters Conference, of which the respondent is a member, rendering the issuance of an order to cease and desist unnecessary.

The hearing examiner's conclusions that the respondent's claims and representations are misleading and likely to be deceptive are not seriously contested. The fact that certain of the statements, when

considered alone, may be true, is no justification for their use where the over-all impression created thereby is false. *P. Lorillard Company v. Federal Trade Commission*, 186 F. 2d 52 (C.A. 4, 1950). As said by the Supreme Court in *Donaldson, Postmaster General v. Read Magazine, Inc., et al.*, 333 U.S. 178, 188 (1948) :

"Advertisements as a whole may be completely misleading although every sentence separately considered is literally true. This may be because things are omitted that should be said, or because advertisements are composed or purposely printed in such a way as to mislead." Nor is it necessary that actual deception be proved or found in a proceeding under Section 5 of the Federal Trade Commission Act. A showing that the advertisements in question have a tendency or capacity to deceive is all that is required. *Progress Tailoring Co., et al. v. Federal Trade Commission*, 153 F. 2d 103 (C.A. 7, 1946). And this, we think, the examiner correctly found to be the case.

In its decision in the matter of The American Hospital and Life Insurance Company, the results of which are applicable here, the Commission held that the respondent's advertising representations disseminated in interstate commerce are subject to the Commission's jurisdiction regardless of the existence of state regulations covering the intrastate dissemination of the same material. The fact that the respondent prepared, assembled and mailed to its agents in the various states, for local distribution, advertising material containing all of the statements alleged to have been false is undenied, and there can be no doubt that by so doing the respondent was engaging in an interstate commercial activity. In the view the Commission takes of its jurisdiction, the further fact that some of the representations may not have been made in states not having regulatory statutes is wholly immaterial, and the respondent's argument on this point is accordingly rejected.

The contention that the proceeding is moot and devoid of public interest because of discontinuance of use of certain of the representations is likewise without merit. As pointed out by the examiner, dismissal of a proceeding on the ground of discontinuance is discretionary with the Commission. In the exercise of its discretion, the Commission must necessarily consider, among other things, whether there is a likelihood that the practice found to have been unlawful will be resumed in the absence of an order prohibiting it—and this, in turn, is governed by "all the facts which include the attitude of respondent towards the proceedings, the sincerity of its practices and professions of desire to respect the law in the future and all other facts." *Eugene Dietzgen Co. v. Federal Trade Commission*, 142 F. 2d 321, 330 (C.A. 7, 1944), cert. denied, 323 U.S. 730. The record dis-

1385

Opinion

closes that of the 45 separate pieces of advertising material introduced into evidence, containing statements of the kind alleged in the complaint to have been deceptive, 28 were still being used as of the date the complaint was issued. Moreover, it has been the respondent's contention throughout this proceeding that its advertising, including advertising it no longer uses, has not been deceptive or in any manner unlawful; and that the respondent has offered no assurances of any kind that it will not resume the use of all of the questioned representations once this proceeding is disposed of. The respondent's argument that "The strongest assurance the purchasing public can have that it will be treated fairly will be found in an aware dedication of a company to its public responsibility" is not convincing in the light of the numerous claims which have been found on this record to have been false and deceptive, and the Commission is in full agreement with the examiner that the public interest requires the issuance of an appropriate order to cease and desist under these facts.

In paragraphs 19 to 22, inclusive, of the initial decision, the examiner discusses the respondent's advertising statements with respect to the dollar amounts payable to its policyholders for losses due to operations. These statements, the complaint alleged, and counsel in support of the complaint now contends, are false and deceptive because they represent, contrary to fact, that the policies provide indemnification for each and every operation up to an amount of \$300. The examiner, however, being of the opinion that the contended for impressions are "far-fetched" and "not reasonably to be expected," read the statements as meaning that some, but not necessarily all, of the insured's surgical expenses will be paid on a sliding scale or schedule ranging from \$5.00 to \$300.00, and accordingly found that the statements accurately reflect the coverage provided by the policies. The question for determination now is which of these conflicting points of view is more nearly correct.

The respondent's advertising statements of financial benefits payable under its policies for losses due to operations are as follows:

Surgical Operations, whether performed in or out of the hospital, are paid up to \$300.00 IN ADDITION TO HOSPITAL BENEFITS. FULL benefits are paid to all insured members of the family group.

SURGERY BILLS from \$5.00 to \$300.00 for sickness or accident.

Pays surgical operation expense up to \$300.00.

Surgical plan—to \$300.00.

Three choices of surgical operation benefits \$5.00 to \$150.00, \$7.50 to \$225.00, \$10.00 to \$300.00.

Your Doctor Bills Paid AT HOME, AT HOSPITAL, AT YOUR DOCTOR'S OFFICE.

\$10 to \$300 Available Surgical Operation Fees.

Pays surgical operation fees up to \$150.00.

Opinion

52 F. T. C.

Who Pays These Bills? YOU SHOULD BE FULLY PROTECTED AGAINST ALL THESE EXPENSES. * * * NEVER BEFORE HAS SUCH PROTECTION BEEN OFFERED.

The policies to which these statements refer clearly do not provide for payments up to \$300 for every operation, but have attached to them riders containing schedules of various amounts payable for specified types of operations (at least two of the policies have the schedules included in the policies themselves). The number of operations covered by the schedules varies from forty-seven in the case of one, to ninety in the case of two others, and the number for which the maximum amount of \$150 or \$300 is payable (depending on the amount of premium paid) varies from two in some instances to six in some of the others, with the operations for which payments of \$25.00 or less are provided running from 21 to 43. In the case of a tonsillectomy or adenoidectomy, the typical allowance under the schedules is \$25.00, and even this amount is not paid, nor will payment be made for an appendectomy, herniotomy, hemorrhoidectomy, or operations for any injury or disease of the female generative organs, unless the rider shall have been in force for not less than six months from date of issue.

In considering a similar situation in *The American Hospital and Life Insurance Company* case, we said:

"Appraising this advertisement as it is likely to be read by unsuspecting, incautious members of the purchasing public, we gain the impression that the policy will indemnify up to a maximum sum of \$150 for any surgical operation serious enough to cost such an amount. Thus, if a tonsillectomy cost \$50, we would think it reasonable to expect that one insured by the policy would be protected to that extent. The advertisement is therefore deceptive and misleading in that it promises benefits which the policy does not corroborate."

Our conclusion is no different here. As the courts have uniformly recognized, it is not the trained and experienced experts who need protection, but the members of the buying public who, in making purchases, are governed largely by appearances and general impressions. Furthermore, the ultimate impression upon the mind of a reader arises from the sum total of not only what is said in an advertisement but also of all that is reasonably implied. *Charles of the Ritz Dist. Corp. v. Federal Trade Commission*, 143 F. 2d 676 (C.A. 2, 1944). And it seems obvious to us that the statements referred to, especially when read in conjunction with such superlatives as "The Most Complete Coverage," "Complete Protection," "All Inclusive Hospital—Surgical—Nurse Protection," and "Maximum Protection at Moderate Cost," which have also appeared in the respondent's

1385

Order

advertisements, are almost certain to mislead readers into thinking they are getting protection which the policies do not provide. The respondent's practice of describing in its advertising the maximum benefits that may be received under the policies without disclosing the schedule of payments for which the policies actually provide is thus unfair and deceptive within the meaning of the Federal Trade Commission Act.

The appeal of counsel supporting the complaint is granted, the appeal of respondent is denied, and the initial decision will be modified in conformity with this opinion.

Commissioners Gwynne and Mason dissented.

FINAL ORDER

Counsel in support of the complaint and respondent, National Casualty Company, having respectively filed their cross-appeals from the initial decision of the hearing examiner in this proceeding, and the matter having been heard on briefs and oral argument; and the Commission having rendered its decision granting the appeal of counsel in support of the complaint and denying the appeal of respondent and directing modification of the initial decision in conformity with the Commission's opinion:

It is ordered, That the following paragraphs be, and they hereby are, substituted for paragraphs 20 to 22, inclusive, of the findings as to the facts contained in the initial decision:

"20. Through such statements, respondent has represented, among other things, that the policies to which they refer provide indemnity up to a maximum sum of \$300 for any operation serious enough to cost such an amount.

"Respondent's policies do not so provide. Under the terms of the policies, payments on account of surgical operations are in accordance with a schedule of fixed fees for different types of operations. Of the numerous operations listed, varying with the different policies from forty-seven to ninety, only a very small number (ranging from two to six on the different schedules) call for payments of as much as \$150 or \$300 (depending on the amount of premium paid). By way of contrast, the operations for which payments of \$25.00 or less are provided, regardless of the actual cost to the policyholder, range from twenty-one in the case of one of the schedules to forty-three in the case of another. Furthermore, according to the terms of the policies, no payments will be made for tonsillectomy, adenoidectomy, appendectomy, herniotomy, hemorrhoidectomy, or for operations for any injury or disease of the female generative organs unless the policy shall have been in force for not less than six months from date of

Order

52 F. T. C.

issue. None of these limitations or conditions is disclosed in the advertising.

"21. Most of the representations set out in paragraph 19 were distributed in all states; others only in some states.

"22. Respondent's representations referred to in paragraphs 19 and 20 have the tendency and capacity to mislead and deceive, and, in the absence of an accompanying schedule clearly disclosing the payments for which the policies provide, are false and deceptive."

It is further ordered, That the following paragraphs be, and they hereby are, substituted for the conclusions of law included in said initial decision:

"1. The Federal Trade Commission has jurisdiction over all of the respondent's acts and practices alleged in the complaint to be unlawful.

"2. The public interest in the proceeding is clear and substantial.

"3. The use by respondent of the statements and representations, found herein to be false and deceptive, with respect to the terms and conditions of its policies of insurance, and its failure to reveal the limitations of the coverage of said policies, have the tendency and capacity to mislead and deceive a substantial portion of the purchasing public into the erroneous and mistaken belief that said statements and representations are true and to induce the purchase of said policies of insurance because of such erroneous and mistaken belief.

"4. The aforesaid acts or practices of respondent as above set forth are all to the prejudice and injury of the public and constitute unfair and deceptive acts or practices within the intent and meaning of the Federal Trade Commission Act."

It is further ordered, That the following order be, and it hereby is, substituted for the order contained in said initial decision:

It is ordered, That respondent, National Casualty Company, a corporation, and its officers, agents, representatives and employees, directly or through any corporate or other device, in connection with the offering for sale, sale and distribution in commerce, as "commerce" is defined in the Federal Trade Commission Act, of any accident, health, hospital or surgical insurance policy, do forthwith cease and desist from representing, directly or by implication:

"1. That any such policy may be continued in effect by the insured upon the payment of stipulated premiums, indefinitely or for any stated time, unless full disclosure of any other provision or condition of termination contained in the policy is made conspicuously, prominently, and in sufficiently close conjunction with the representation as will fully relieve it of all capacity to deceive.

"2. That no medical examination is required, unless the respondent actually insures the policyholder without regard to his physical condi-

1385

Order

tion before or after issuance of the policy; or otherwise representing that the condition of the insured's health at the time of issuance of the policy will not be considered by the respondent in determining its liability thereunder, or that the respondent will not, as a claims practice, require proof of good health of the insured at the time of issuance of the policy.

"3. That any policy provides for payment in full or in any specified amount or for payment up to any specified amount for any medical, surgical or hospital service, unless the policy provides that the actual cost to the insured for that service will be paid in all cases up to the amount represented, or unless full disclosure of the schedule of payments for which the policy provides is made conspicuously, prominently, and in sufficiently close conjunction with said representation as will fully relieve it of all capacity to deceive.

"4. The extent or duration of either coverage or benefits payable under the terms of any policy, unless a statement of all the conditions, exceptions, restrictions and limitations affecting the indemnification actually provided is set forth conspicuously, prominently, and in sufficiently close conjunction with the representation as will fully relieve it of all capacity to deceive.

"It is further ordered, That respondent, National Casualty Company, shall, within sixty (60) days after service upon it of this order file with the Commission a report in writing setting forth in detail the manner and form in which it has complied therewith."

It is further ordered, That the initial decision of the hearing examiner, as modified herein, is hereby adopted as the decision of the Commission.

Commissioners Gwynne and Mason dissenting.

Complaint

52 F. T. C.

IN THE MATTER OF

LEANN FINE FURS, INC., ET AL.

CONSENT ORDER, ETC., IN REGARD TO THE ALLEGED VIOLATION OF THE
FEDERAL TRADE COMMISSION AND THE FUR PRODUCTS LABELING ACTS

Docket 6503. Complaint, Feb. 10, 1956—Decision, May 24, 1956

Consent order requiring furriers in East St. Louis, Ill., to cease violating the Fur Products Labeling Act by failing to disclose in newspaper ads, on attached labels, and on invoices information required by the Act; and in such advertising, naming animals other than those specified in the Fur Products Name Guide, and misrepresenting the amount of savings possible to purchasers.

Before *Mr. Robert L. Piper*, hearing examiner.

Mr. R. D. Young, Jr. for the Commission.

Brady, Donovan & Hatch, of East St. Louis, Ill., for respondents.

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act and the Fur Products Labeling Act, and by virtue of the authority vested in it by said Acts, the Federal Trade Commission, having reason to believe that LeAnn Fine Furs, Inc., a corporation, and David Sandow and Sylvia Sandow, individually and as officers of said corporation, hereinafter referred to as respondents, have violated the provisions of said Acts and the Rules and Regulations promulgated under the Fur Products Labeling Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues its complaint, stating its charges in that respect as follows:

PARAGRAPH 1. The corporate respondent LeAnn Fine Furs, Inc., is a corporation, organized and existing under and by virtue of the laws of the State of Illinois.

Individual respondent David Sandow is President and Treasurer, and individual respondent Sylvia Sandow is Secretary and Vice-President of the corporate respondent. These individual respondents formulate, direct and control the acts, practices and policies of the corporate respondent. The office and principal place of business of all said respondents is located at 334 Collinsville Avenue, East St. Louis, Illinois.

PAR. 2. Subsequent to the effective date of the Fur Products Labeling Act on August 9, 1952, respondents have introduced, sold, advertised, offered for sale, transported and distributed fur products in