

IN THE MATTER OF
TRAVELERS HEALTH ASSOCIATION

ORDER, ETC., IN REGARD TO THE ALLEGED VIOLATION OF THE
FEDERAL TRADE COMMISSION ACT

Docket 6252. Complaint, Oct. 14, 1954—Decision, Dec. 20, 1956

Order requiring an insurance company doing an interstate business by mail from its home office in Omaha, Nebr., to cease misrepresenting in pamphlets and form letters the terms and conditions of its health insurance policies.

Before *Mr. J. Earl Cox*, hearing examiner.

Mr. William A. Somers for the Commission.

Fraizer & Fraizer, of Lincoln, Nebr., for respondent.

FINDINGS AS TO THE FACTS, CONCLUSIONS AND ORDER

Pursuant to the provisions of the Federal Trade Commission Act, the Federal Trade Commission on October 14, 1954, issued and subsequently served its complaint upon the respondent, Travelers Health Association, a corporation, charging it with the use of unfair and deceptive acts and practices in commerce in the sale of health insurance policies in violation of the provisions of the Federal Trade Commission Act. After the filing of answer, hearings were conducted at which evidence in support of and in opposition to the allegations of the complaint was introduced before a hearing examiner of the Commission. On March 29, 1956, the hearing examiner filed his initial decision in which it was held that certain of the complaint's charges were sustained by the greater weight of the evidence and that other allegations, as there designated, were not so supported by the record, respecting which latter category of charges the initial decision's order provided for dismissal.

Within the time permitted by the Commission's Rules of Practice, counsel in support of the complaint and counsel for the respondent filed their respective appeals from the initial decision, and the Commission after considering said appeals and the record herein, including the briefs filed in support of and in opposition to the appeals and the oral arguments of counsel, has rendered its decision granting the appeal of counsel supporting the complaint and denying the appeal of the respondent; and the Commission being now fully advised in the premises, makes the following findings as to the facts, conclusions drawn therefrom, and order, which together with the Commission's aforesaid decision ruling on the appeals shall be in lieu of the initial decision of the hearing examiner.

FINDINGS AS TO THE FACTS

PARAGRAPH 1. The respondent, Travelers Health Association, is a corporation duly organized, existing and doing business under and by virtue of the laws of the State of Nebraska, with its office and principal place of business located at 1613 Farnam Street, Omaha, Nebraska. It was incorporated in 1904.

PAR. 2. The respondent is now, and for more than two years last past has been, engaged in the business of insurance in commerce, as "commerce" is defined in the Federal Trade Commission Act, by soliciting and entering into insurance contracts with persons living in various States of the United States other than the State of Nebraska. Its business has been and is substantial. The dollar volume of premium receipts, including those from Nebraska, has been as follows: for 1952, \$568,000; for 1953, \$560,000; and for 1954, \$548,000.

The respondent during the two years last past has issued policies providing indemnification for losses resulting from sickness, designated by it as DW N-49, CW N-49, CD N-49, CS N-49, CD O-49, CD O 1-49 and DW O-49. These policies are practically uniform except that amounts of benefits differ and some policies are for men, others are for women.

PAR. 3. The respondent is licensed only in the States of Nebraska and Virginia, although it transacts business by mail with residents of all the states. Its advertising, promotional activities and all other business practices originate in and are carried on from its home office in Omaha, Nebraska. Its advertising is mailed from Omaha, its policies are issued and premium payments are received there, and claims are filed, serviced and paid at or from that office. No policies are sold by or through agents. Respondent pays taxes in Nebraska on premiums collected from all policyholders excepting only those who live in Virginia. Taxes on premiums collected from residents of Virginia are paid to Virginia. Annual statements are filed in Nebraska and Virginia.

The respondent does no newspaper or magazine advertising, but solicits sales by mailing, at intervals and in continuity, a series of circular letters to "white-collar" workers. With each mailing an application blank is enclosed, on the reverse side of which there is advertising material describing policy provisions. Some of the mailings include a descriptive leaflet, "Our Plan Explained"; some include a "Choose the Right Amount" slip which suggests that care be taken in selecting the policy which provides the proper amount of benefits; some contain a slip which has a testimonial on one side

and on the other side a statement as to the date to which coverage is to be provided if a membership deposit is sent in; sometimes a copy of the respondent's annual statement is enclosed. There are other letters for lapsed policyholders urging them to reinstate. Many letters are used. Ordinarily an individual prospect will receive a series of eight letters, although some may receive as many as thirty. The letters are not broadcast to the public, but are addressed to individuals who have been recommended by respondent's policyholders.

PAR. 4. Included respectively in the brochure containing the application form and in a form letter used by the respondent in soliciting sales for its insurance contracts are the following statements:

There is no age limit to which a member may continue protection.

Practically all "white collar" workers—business or professional men—are eligible, if in good health and between eighteen and fifty-five years of age. There is no age limit to continue membership and no increase in premiums to those of advanced age.

The complaint in effect alleges that through use of the foregoing statements the respondent represents that its policies provide continuing indemnification for loss as long as the policyholder makes prompt payment within periods and in amounts stipulated by the policies. Such representation is misleading and deceptive, the complaint charges, for the reason that the respondent's policies cannot be continued in effect by the insured if the respondent wishes to cancel them. Under the policies' express terms the respondent may refuse to accept premium payments and cancel a member's policy at any time, for any reason or for no reason, upon written notice and return of the current premium payment. The record shows moreover that when the respondent's claims experience with a member indicates he is no longer a desirable insurance risk from a health standpoint, cancellation is effected by the company.

The impressions and beliefs which may reasonably be engendered among prospective insureds by the advertising statements noted above are to be additionally appraised in the light and perspective of other representations and statements appearing in the respondent's advertising. Certain of the respondent's form letters identify its insurance program variously as "a way to be sure of having extra money to pay the expense of sickness" and one which can "assure" freedom from financial worries when sick, and membership in the company is stated additionally to "guarantee" a definite income in case of illness. The central theme of the advertising emphasizes that immediate or seasonable purchase of the protection afforded by

respondent's policies assures comfort and freedom from financial anxiety. In this setting, the statement that age is no bar under the policies to continuance of membership and insurance protection clearly represents and implies that the respondent's policies may be kept in force continuously at the option of the insured. Inasmuch as this is contrary to the true facts, such representation is misleading and deceptive.

PAR. 5. In the form letters used by the respondent the following additional statements appear:

At home, in the hospital, in a hotel—no matter where you are—when sickness prevents you from working and you have physician's care, we pay.

Benefits are paid for one day up to one hundred four weeks. All diseases, except genital, are covered.

Briefly, we pay for time lost through sickness. All diseases, except genital, are covered. You choose the amount you need \$25, \$50, \$75 or \$100 a week. We pay for one day up to one hundred four weeks of total disability. Hospitalization or surgery are not required. Just total disability.

Through use of the foregoing statements and representations, respondent represents that its policies provide indemnification from one day to 104 weeks, in specified amounts, for loss of time from work due to disability caused by all disease or sickness, except genital, incurred after the effective date of the policy. In truth and in fact, the policies do not so provide and the respondent's representations in this regard are false, misleading, and deceptive. In lieu of indemnification as aforesaid, the terms of the policy provide that liability exists only in the event the sickness causing disability begins more than 30 days after issuance of the policy. The fact that no liability exists under the policies if the illness is traceable to a condition existing prior to 30 days after issuance is not clearly or adequately disclosed in the respondent's promotional matter. Also excluded under the policies, and similarly without express reference being made in the advertising to exclusions in that respect, are losses sustained or contracted in consequence of the insured being intoxicated or under the influence of narcotics not administered on advice of a physician.

Under other terms of the policies, benefits for disability due to paralysis are limited to one-half of the standard weekly benefits specified therein and are restricted to a maximum of 10 weeks, which conditions and restrictions are not disclosed in the advertising matter. All of the respondent's policies, save one, provide reduced benefits for the first week's confinement from illness and any reference thereto similarly is absent from the promotional material. Furthermore, the policies contain a provision that if the insured carries other coverage for the same loss as that covered

thereby without written notice to the Association, then the respondent shall be liable only for such portion of its promised indemnity as said indemnity bears to the total of like indemnity in all policies covering such loss of the insured. The existence of this potential limitation on indemnities afforded is not disclosed in any of the respondent's promotional matter.

PAR. 6. The complaint further alleges in effect that certain additional exceptions, limitations and restrictions in the respondent's policies likewise have served to render false and misleading the statements and representations of the advertising noted in the preceding paragraph with respect to the indemnification afforded by the respondent. The policy provisions to which such charges relate concern, among others, those restricting maximum benefits for disability from tuberculosis, neuritis, arthritis, rheumatism, nervous or mental trouble to half the stipulated weekly rates and limiting them to a maximum of ten weeks, and others entirely excluding benefits for disability due to prostatitis and hernia. The record, however, fails to support informed determinations that a capacity to deceive in respect to those limitations and exclusions inheres in the respondent's promotional material. Hence, these charges are deemed to be without merit and dismissed hereby.

PAR. 7. In various form letters disseminated by the respondent to prospective purchasers of its policies, the following statements appear:

Business and professional men, in good health and under 55 years of age, may join. No medical examination is required. Just answer the questions in your application enclosed and send it to us with the money needed to cover the benefits you choose.

You are invited to apply for this vital, inexpensive protection of your most valuable asset—your earning power. No medical examination necessary. Just complete and return the application, using blank enclosed, with \$2.00 for each \$25.00 unit.

Through use of the statement that no medical examination is required, the respondent represents that it, in determining whether cash benefits will be paid for loss resulting from sickness or diseases arising after the effective date of the policy, will not take into consideration the physical condition of the insured prior to or at the time of issuance of the policy. While physical examinations are not required prior to issuance of policies, applicants are instructed to submit answers in writing to various questions included in the application form relating to physical condition and past ailments. By the terms of its policies, the company, however, has the right to subject its insureds to physical examinations as often as it may reasonably require during the pendency of any claim thereunder,

including the right to autopsy in case of death. The state of health of the insured prior to, contemporaneously with, and subsequent to issuance of his policy is a controlling consideration in determining eligibility thereunder for its benefits. This is clear inasmuch as the policies contain provisions to the effect that no indemnity will be paid for disability if the cause is traceable to a condition existing prior to 30 days after their issuance.

That the respondent's application form and certain of the form letters make mention of good health as a requirement for applicants is immaterial. The reference to current health in no manner serves to disclose that medical examinations subsequently may be required of the policyholder or to negate the erroneous impressions and beliefs engendered by the advertising, namely, that benefits will be paid without regard to the insured's prior condition of health. There can be no doubt but that numbered among those importuned in the advertising to fill out and transmit the application, together with the money needed to cover the benefits of their choice, have been many persons regarding their present health as robust, even though they may have had serious afflictions in the past. Their current vigor of health and the attendant deemphasis or silence of the advertising on matters relating to the prospect's prior condition of health as having bearing on present insurability notwithstanding, the potential effects of an applicant's past ailments on future health are material considerations in determinations of eligibility for initial purchase and continuance of the respondent's insurance protection.

CONCLUSIONS

1. The Federal Trade Commission has jurisdiction over all the respondent's acts and practices found herein to be false and misleading.

2. The public interest in this proceeding is clear and substantial.

3. The use by the respondent of the statements and representations found in Paragraphs 4, 5, and 7 above to be false and misleading with respect to the terms and conditions of its policies of health insurance and its failure to reveal the limitations in coverage afforded by its policies has had 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 thereby the purchase of said policies of insurance.

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

Opinion

53 F.T.C.

ORDER

It is ordered, That respondent Travelers Health Association, 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 health insurance policy or policies, 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 any policy provides for indemnification against disability or loss due to sickness or disease, 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.

3. 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 the health of the insured at the time of issuance of the policy.

It is further ordered, That respondent Travelers Health Association 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.

Commissioner Gwynne concurring in the result and Commissioner Tait not participating.

OPINION OF THE COMMISSION

By ANDERSON, Commissioner:

The initial decision filed by the hearing examiner held that certain of the charges of the complaint were sustained by the greater weight of the evidence and ruled that others were not so supported; and the order contained in the initial decision requires cessation of the practices to which the first category of charges related and

provides for dismissal of the latter. The cross-appeals separately filed by the counsel for the respondent and by counsel supporting the complaint except to various rulings in that decision which were adverse to the appealing parties' respective contentions in the course of the hearings below.

The complaint under which this proceeding was instituted charged that the respondent has engaged in unfair and deceptive acts and practices violative of the Federal Trade Commission Act in connection with the offering for sale and sale in commerce of its health insurance policies. From its office in Omaha, Nebraska, the respondent solicits sales of its policies to "white collar" workers located in the various States of the United States. No sales agents are employed by the respondent and all sales are promoted through the mails by means of pamphlets and a series of form letters describing the indemnities, benefits and advantages afforded by its policies. Sample policies are not included in the respondent's routine mailings to its prospective insureds.

The first of the exceptions interposed under the appeal of counsel supporting the complaint pertains to the initial decision's holding that the record does not support the complaint's charges of deception allegedly engendered through statements in the respondent's advertising that there is no age limit to which a member can continue his protection. In this connection, the complaint charges that the respondent has represented thereby that its policies provide continuing indemnification for losses resulting from sickness or disease so long as the policyholder makes premium payments within periods of time and in amounts fixed by the terms of such policies. In lieu of so providing, the policies specify that they can be cancelled at any time, for any reason, upon written notice by the respondent. For reasons stated in the Commission's findings as to the facts, we think that the hearing officer clearly erred in failing to find that the challenged statements have served to engender erroneous impressions and beliefs among prospective purchasers that the respondent's policies may be kept in force at the option of the insured. Having elected to stress in its advertising that the policies contain no provisions precluding the insured, by reason of age, from continuing his selected protection against financial loss from sickness, the respondent, if it is to relieve its representation of its deceptive tendency thus generated, must make full disclosure of other relevant policy contingencies which foreclose the insured's exercise of any option in that respect.

The remaining exception urged under the appeal of counsel supporting the complaint relates to the initial decision's dismissal of the

complaint's charges challenging, as false and misleading, the statement in the respondent's advertising that no medical examination is required. Even though examination by a physician is not required prior to issuance of a policy, the company by the terms of its policies has the right to examine the insured "so often as it may reasonably require" during the pendency of a claim, which provision is not referred to in the advertising. Concern over personal health is practically universal and medical examinations are held in dread and awe by many people. Proffered waivers in such respect constitute highly material matters and erroneous impressions necessarily result unless they contain a full and complete disclosure of the facts in that regard.

We think that, when construed in the context in which used in the respondent's advertising, the statement emphasizing that no medical examination is required reasonably represents and implies that the respondent does not take into consideration the physical condition of the insured prior to or at the time of issuance of the policy when determining whether benefits will be paid. It was error for the hearing examiner to hold otherwise and to fail to reach conclusions that such representation is deceptive. Its falsity is evident from the fact that the physical condition of the insured prior to, contemporaneously with, and even 30 days subsequent to date of issuance of the policy are controlling considerations for securing respondent's insurance protection and payment of benefits.

Nor is it material that the application form and some of the respondent's letters mention good health as a requirement for applicants. As noted in the Commission's accompanying findings as to the facts, many individuals may justifiably regard their current states of health as robust and vigorous even though they may have had ailments in times past presenting possibilities of recurrence or other future impairment to health. Prospective purchasers of insurance are entitled to rely on the sales representations made and are not under obligation to investigate whether promised waivers in medical or other requirements are in fact conditional and restricted in their scope.

The appeal of counsel for the respondent contends that the Commission lacks jurisdiction in this proceeding; and it argues that under the provisions of the McCarran-Ferguson Act (Public Law 15, 79th Cong., 15 U.S.C.A. § 1011-15), power to regulate the respondent's sales practices is vested solely in insurance authorities of the State of Nebraska, the State granting its corporate charter and where the respondent has its sole place of business. As previously noted, however, the respondent solicits sales of its policies solely by means of the mails among purchasers residing in states other

than Nebraska and transmits them, when sold, to purchasers through the same channels. For reasons stated in our opinion in the matter of the *American Hospital and Life Insurance Company*, Docket No. 6237, we do not believe that the statute admits of the construction placed upon it by the respondent. The hearing officer correctly found that the Commission had jurisdiction over such of respondent's practices in interstate commerce as might be found to be unfair and deceptive.

The respondent's appeal additionally urges that the Commission is estopped from maintaining these proceedings for the reason that its advertising matter was approved by a member of the Commission's staff in the course of conferences and correspondence occurring in 1950 and 1951. It appears that, after the Commission promulgated its trade practice rules relating to the advertising and sales promotion of mail order insurance, the respondent submitted copies of four pieces of advertising literature for a staff member's consideration and comment in the light of those rules. Those particular advertisements, or subsequently used revisions thereof, were received as exhibits in this proceeding; and the record indicates that the attorney interposed no objections to such advertisements or the respondent's proposed revisions thereof as not in accord with those since rescinded trade practice rules. These matters notwithstanding, several of the advertising statements quoted in the complaint and alleged to be deceptive do not appear in those four particular exhibits but are contained in other disseminated promotional material. In these circumstances, it cannot be concluded that institution of this adjudicative proceeding and its determination on its merits is inequitable or improper; and such disposition is clearly required in the public interest inasmuch as the respondent is vigorously contesting the merits of the charges and defending the legality of the challenged sales practices.

Even though the record situation respecting prior contacts by the respondent with Commission representatives were other than as noted above, the respondent's argument of equitable estoppel requiring suspension of these proceedings would be without legal merit. As an administrative agency charged with the protection of the public interest, the Commission is not precluded from taking action to that end because of mistaken action or lack of action on its part in the past. *P. Lorillard Co. v. F.T.C.*, 186 F.2d 52 (C.A. 4, 1950); *N.L.R.B. v. Baltimore Transit Co., et al.*, 140 F.2d 51 (C.A. 4, 1944).

Brief reference is warranted with respect to certain matters not raised by the appeals but considered in the course of our review. Additional charges in the complaint pertain to statements quoted

from the advertising which are alleged to constitute representations that indemnification is provided by the policies for loss of time from one day up to 104 weeks for all sickness, except genital, occurring after the effective date of the policy; and other relevant charges allege that the advertising's promises of such benefits are contrary to the true facts for reasons, among others, that the actual policy terms specify reduced benefits for certain sicknesses and the exclusion of others. We concur in the hearing examiner's conclusions that certain of the policies' restrictions, limitations and exclusions which he has designated, as to which the promotional material is either entirely silent or presence of which is not clearly and adequately disclosed, serve to render false the advertised promises of benefits. We think, however, that the hearing examiner erred in failing to reach like conclusions respecting the advertising's failure similarly to clearly reveal the true facts of the policies' exclusions from coverage of all sickness sustained or contracted in consequence of use of intoxicants or narcotics, and also material facts relating to the reduced or prorated benefits afforded under the contracts in the event of the insured's subsequent purchase of additional insurance without due notice to the respondent. Appropriate findings in these respects are included in the Commission's findings as to the facts.

The respondent's appeal is hereby denied and the appeal of counsel supporting the complaint is granted. Accordingly, the initial decision is vacated and set aside, and our findings as to the facts, made on consideration of the whole record including the initial decision, and conclusions and order to cease and desist are issuing in lieu thereof.

Chairman Gwynne concurs in the result.

Commissioner Tait did not participate in the decision herein.

CHAIRMAN GWYNNE, CONCURRING IN THE RESULT

The majority bases its conclusion of jurisdiction on reasons stated in the opinion in the matter of American Hospital and Life Insurance Company, Docket No. 6237. I agree that there is jurisdiction, but for the reasons set out in this opinion.

Involved here, is the further interpretation of Public Law 15 (McCarran Act). The joint dissent in the American Hospital and Life case sets out my views as to the general purposes and intent of the McCarran Act and as to its application to the facts in that case. There, respondent insurance company operated exclusively through agents in various states, in which it was duly licensed under the respective state laws. At the time of the issuance of the Commission order, every such state had adopted the Model Code, or equiva-

lent legislation. The advertising practice complained of involved bundles of advertising matter mailed from the home office to the company's agents in the several states and disseminated there by such agents. There was no advertising by newspaper, radio, or television; nor did respondent solicit or sell policies by mail.

Section 2(b) of the McCarran Act provides in substance, that after January 1, 1948, the Federal Trade Commission Act shall be applicable to the business of insurance to the extent that such business is not regulated by state law. The question in American Hospital and Life and also in this case is: Are the advertising practices in question regulated by state law. In the former case, the dissenting opinion concluded that the practices were so regulated and that, therefore, the Federal Trade Commission had no application.

In the instant case the essential facts were found by the Hearing Examiner to be as follows:

Respondent, Travelers Health Association, is a corporation duly organized, existing and doing business under and by virtue of the laws of the State of Nebraska, with its office and principal place of business located at 1613 Farnam Street, Omaha, Nebraska. * * *

* * * * *

Respondent is licensed only in the States of Nebraska and Virginia, although it transacts business by mail with residents of all the states. Its advertising, promotional activities and all other business practices originate in and are carried on from its home office in Omaha, Nebraska. Its advertising is mailed from Omaha, its policies are issued there, premium payments are received, claims are filed, serviced and paid at or from that office. No policies are sold by or through agents. Respondent pays taxes in Nebraska on premiums collected from all policy-holders excepting only those who live in Virginia. Taxes on premiums collected from residents of Virginia are paid to Virginia. Annual statements are filed in Nebraska and Virginia.

Respondent does no newspaper or magazine advertising, but solicits sales by mailing, at intervals and in continuity, a series of circular letters to "white-collar" workers. * * *

The basis on which respondent denies the jurisdiction of the Federal Trade Commission is indicated by the following in its answer:

For answer to the complaint respondent alleges that the Federal Trade Commission is without jurisdiction in this matter because in truth and in fact each and every activity of the respondent is regulated, supervised and otherwise overseen by the Director of Insurance and the Department of Insurance of the State of Nebraska, which under Nebraska state law, fully regulate such activities within the meaning and scope of Public Law 15 enacted by the Congress of the United States, * * *

And by the following from its brief on appeal:

The Regulatory Statutes of the State of Nebraska, actually and actively enforced by the Nebraska Insurance Department, completely eliminate Federal Trade Commission jurisdiction.

Public Law 15 provides the Federal Trade Commission Act shall be applicable to the business of insurance "to the extent that such business is not regulated by state law." The powerful Nebraska statutes and their actual enforcement by the Nebraska Insurance Department, regulate advertising conducted by Nebraska domiciled companies writing sickness insurance, comprehensively, completely and effectively, whether within or without the state.

The question therefore is: Do the statutes of Nebraska regulate the business of insurance in other states to such an extent that, under the McCarran Act, the Federal Trade Commission Act is not applicable?

It is my opinion that they do not for the following reasons:

First, the Nebraska statutes, for the most part do not purport to operate beyond the State of Nebraska. The insurance laws of Nebraska include the so-called Model Code adopted by many states following the passage of the McCarran Act. The language discloses that the Nebraska statutes were intended to operate only within that state. This is shown by the following:

44-1501. Insurance: trade practices; regulation. The purpose of sections 44-1501 to 44-1521 is to regulate the trade practices in the business of insurance, in accordance with the intent of Congress of the United States as expressed in Public Law 15 of the 79th Congress, by defining, or providing for the determination of, all acts, methods, and practices which constitute unfair methods of competition and unfair or deceptive acts and practices *in this state*, and to prohibit the same.

44-1503. Unfair methods of competition; deceptive acts and practices; prohibited. No person shall engage *in this state* in unfair methods of competition or in unfair or deceptive acts and practices in the conduct of the business of insurance.

44-1506. Unfair methods of competition; deceptive acts and practices; charges; notice of hearing. If the Director of Insurance shall have reason to believe that any person is engaging *in this state* in any such unfair or deceptive act or practice in the conduct of such business, * * *.

44-1515. Other unfair methods of competition and deceptive acts and practices; report by Director of Insurance; hearing. If the Director of Insurance shall have reason to believe that any person engaged in the business of insurance is engaging *in this state* in any method of competition or in any act or practice in the conduct of such business, * * *. [Emphasis supplied in all instances.]

Section 44-750; 44-751 and 44-752 also apply only to companies or agents doing business in Nebraska.

Respondent also relies upon Section 44-712.01, which provides:

Sickness and accident insurance; Director may approve policies for another state; rule.

SEC. 3. If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the director that any such policy is not subject to approval or

disapproval by such official, the Director of Insurance may by ruling require that such policy meet the standards set forth in section 44-712, and sections 44-713 to 44-728.

Sections 44-713 to 44-728 have to do with standard policy provisions, proof of loss, actions on the policy, etc., rather than to advertising.

Even if the statutes, or any of them, could be construed to operate generally in other states, in the same sense that they operate in Nebraska, they would be of doubtful constitutionality. As a general principle, a state is a sovereign whose powers are limited to its own boundaries and to protecting its own citizens. It is true, instances may be found where the carrying out of these powers may affect the people and even the laws of other states. I do not agree, however, that these cases are "convincing court decisions indicating that the state of domicile may police acts beyond the borders of such state."

In *Alaska Packers Association v. Industrial Accident Commission of California*, 1935, 294 U.S. 532, a contract made in California for work to be performed in Alaska contained a provision that the parties would be bound by the Alaska Workmen's Compensation law. Nevertheless, a recovery under the California Act, which state claimed jurisdiction in such cases, was upheld by the court. In *Hoopston Canning Company v. Cullen, Superintendent of Insurance of New York*, 1943, 318 U.S. 313, the court held that Reciprocal Insurance Associations which insured property located in New York, although their attorneys-in-fact were located in Illinois, and the contracts of insurance were signed and checks in payment of losses were mailed in Illinois, were subject to regulation under New York laws. Some other important facts were that most of the insurance covered real property in New York; the Associations had for years been licensed to do business in that state and had many actual contacts there. In *Watson v. Employers' Liability Assurance Corporation*, 1954, 348 U.S. 66, the court held that a Louisiana statute permitting direct suit against foreign liability insurers, in the parish where the accident occurred, was enforceable in spite of the fact that the insured party lived outside the state, that the contract was made outside the state, and that the law there recognized the validity of a limitation prohibiting such direct suit. I do not construe *Hammond Packing Company v. State of Arkansas*, 1909, 212 U.S. 322, as holding that the Arkansas statute "could validly be applied to the extra-territorial operations of domestic corporations." As the Supreme Court put it, "the interpretation which the court below gave to the statute was that, it did not purport to forbid or affix penalties to acts done beyond the state, but that it simply forbade a corporation from continuing

to do business within the state after it had done, either within or outside the state, the enumerated acts."

In *Watson v. Employers' Liability Assurance Corporation, supra*, the court said, "As a consequence of the modern practice of conducting widespread business activities throughout the entire United States, this court has in a series of cases held that more states than one may seize hold of local activities which are part of multistate transactions and may regulate to protect the interests of its people, even though other phases of the same transaction might justify regulatory legislation in other states."

These state statutes seize upon various phases of far-flung activities to justify the attempt to protect the interests of the state or its citizens. These laws variously assert jurisdiction on such facts as issuance of a corporate charter, licensing of a foreign corporation to do business in the state, situs of the making of the contract, or of its performance, location of the property involved, place of the accident involved, residence or citizenship of a person affected, and many others. For example, the Florida Unauthorized Insurers Process Act provides that any foreign insurer, not licensed in Florida, which effects issuance or delivery of insurance contracts to Florida residents by mail, thereby appoints the Insurance Commissioner of Florida its agent for service of process in any action arising out of any such contract. In *Parmalee v. Iowa State Traveling Mens Association*, 1953, 206 F. 2d 518, the court, after considering both the due process clause and the McCarran Act, held the statute was enforceable where the facts brought the case strictly under the provisions of the law, which Florida had passed to protect its own citizens. In *Parmalee v. Commercial Travelers Mutual Accident Association of America*, 1953, 206 F. 2d 523, where the policy was delivered by mail to a resident of Kentucky, who thereafter moved to Florida and resided there when the cause of action arose, the court held that the suit could not be maintained under the statute.

The intent of these various statutes is to protect the rights of the citizens of the state passing the laws. It is difficult to see how such laws could be sustained on any other ground. Even then, the court in each individual case must balance the right sought to be protected against the rights of other states or their citizens—which rights might be adversely affected. The balancing of these rights, one against the other, involves the application of the due process clause, and the decision in each case depends upon the particular facts. It is difficult to see how the enforcement, in other states, of Nebraska advertising laws would be of benefit to the citizens of Nebraska.

Finally, this type of law (that is, a law purporting to protect the people of *another state* from deceptive advertising) can hardly be said to be the type of law referred to in Section 2(b) of the McCarran Act. Section 2(b) makes the Federal Trade Commission Act applicable to the business of insurance to the extent that such business is not regulated by state law. I think this refers to the laws of the state whose citizens are being affected by the advertising and not to laws of some other state operating extra-territorially.

The McCarran Act speaks of the "continued regulation * * * by the several states of the business of insurance." Section 2(a) says in part: "The business of insurance and every person engaged therein, shall be subject to the laws of the several states which relate to the regulation or taxation of such business." Prior to *U.S. v. South-Eastern Underwriters Association*, 1944, 322 U.S. 533, the regulation of insurance was a problem for the individual state, subject only to constitutional restraints other than the commerce clause. It was evidently the Congressional intention to maintain each state system, free from the obstacles recently created by South-Eastern Underwriters. This protection of the individual state from the paramount federal power is difficult to reconcile with the theory of making one state subject to the laws of another state, in which laws they have had no part in making.

Reference has already been made to constitutional difficulties which might arise in any attempt to enforce the Nebraska statutes in other states. We will assume that Congress was also aware of these possibilities. Consequently, we should hesitate to adopt the interpretation of the McCarran Act proposed by respondent, unless it is clear that Congress so intended. There is nothing in the law or in the legislative history to indicate such an intention.

Finally, respondent's interpretation is contrary to the general philosophy of our dual system of government and would be confusing and ineffective in operation. We may assume that Nebraska has very good laws regulating insurance and that they are adequately enforced. Suppose we also assume that, through its corporate charter provisions or otherwise, Nebraska may exercise some actual control over the mail order business done in states having no regulation of advertising. Illinois might also insist on enforcing different rules as to its corporations, operating by mail in these same states. This would create a situation of confusion which would make any law enforcement extremely difficult. Under the McCarran Act, a state may enact laws protecting its citizens against certain phases of insurance activity. To the extent that a state does not (or for con-

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stitutional reasons cannot) adopt such legislation, the McCarran Act provides a secondary defense. That defense is not the laws of some other state in which the insurance company is chartered or has its principal place of business; the defense consists of the applicable laws of the federal government. This is the fundamental purpose of the McCarran Act.

Decision

IN THE MATTER OF

ATALANTA TRADING CORPORATION

ORDER, ETC., IN REGARD TO THE ALLEGED VIOLATION OF SEC. 2(d)
OF THE CLAYTON ACT

Docket 6464. Complaint, Nov. 21, 1955—Decision, Dec. 20, 1956

Order requiring a seller of meat products, principally imported hams, under the trade name "Unox," through territorial salesmen and food brokers and direct to grocer retailers including retail chains, approximating sales during 1954 of \$24,000,000, to cease making payments for advertising furnished by a customer which were the result of private negotiations tailored exclusively to fit the desires of the two interested parties, and which were not based on and did not result in a general plan for payment which could be offered to competitors in accordance with Sec. 2(d) of the Clayton Act.

Mr. Andrew C. Goodhope and Mr. Fredric T. Suss for the Commission.

Steptoe & Johnson, of Washington, D.C., for respondent.

INITIAL DECISION BY FRANK HIER, HEARING EXAMINER

Complaint in this matter issued November 21, 1955, and charged respondent with granting advertising allowances to some but not to all of its customers competitively engaged in the resale of respondent's products in violation of subsection (d) of section 2 of the Clayton Act (15 U.S.C. 13) as amended by the Robinson-Patman Act. Answer was filed December 21, 1955, admitting jurisdictional and descriptive facts and the payment of promotional allowances to some of its customers but denying that such promotional allowances were not made available on proportionally equal terms to all of its customers competing in the resale of all its products. After various postponements one hearing was held April 3, 1956, at which the entire case was presented, and the transcript, consisting of 58 pages accompanied by seven exhibits, and the case closed for proof taking the same day. Thereafter proposed findings of fact were submitted by all counsel and the case formally closed on May 17, 1956. Only two witnesses testified, one, the vice president and co-owner of respondent, for the Commission, and the other, respondent's salesman for the Washington territory, for the respondent. Upon consideration of the proposed findings and conclusions submitted by counsel and the entire record in this proceeding, the hearing examiner makes the following: