

Findings

IN THE MATTER OF
NORTH AMERICAN ACCIDENT INSURANCE COMPANY

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

Docket 6456. Complaint, Nov. 18, 1955—Decision, Feb. 20, 1957

Order requiring a Chicago insurance company, doing a nation-wide business through some 2200 agents in all the States, to cease falsely advertising the benefits and coverage of its accident and health insurance policies.

Mr. Philip R. Melangton and Mr. Francis C. Mayer for the Commission.

Mr. Claud C. Cox and Mr. Jacob Logan Fox, of Chicago, Ill., and *Watters & Donovan*, by *Mr. Thomas A. Harnett*, of New York City, for respondent.

INITIAL DECISION BY FRANK HIER, HEARING EXAMINER

Complaint herein issued November 18, 1955, charging respondent with misrepresenting its accident and health policies by soliciting their sale through newspaper advertisements, radio commercials, circulars, and other advertising material which stressed or mentioned only maximum benefits or coverage while omitting actual policy exclusions and limitations, thereby 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). Answers filed admitted the descriptive facts alleged, the excerpts of advertising done and denied misrepresentation, fair excerpting and jurisdiction to proceed as well as voluntary abandonment of a substantial part of the advertising done.

On the issues joined, two hearings were held at the close of which respondent's counsel moved to dismiss the complaint for lack of jurisdiction and insufficient proof to sustain the allegations of the complaint. Proposed findings of fact and conclusions were submitted by all counsel, on consideration of which, with the rest of the record herein, the finding is made that the public interest is clear and substantial, and the hearing examiner makes the following:

FINDINGS AS TO THE FACTS

1. Respondent, North American Accident Insurance Company, is a corporation duly organized, existing and doing business under and by virtue of the laws of the State of Illinois, with its office and

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principal place of business located at 209 South LaSalle Street, Chicago, Illinois.

2. Respondent is, and at all times during the period covered by this proceeding has been, engaged in the business of accident and health insurance, and is licensed to conduct such business in all the 48 states of the United States and in the District of Columbia.

3. In the course and conduct of such business, respondent has been and is now soliciting, selling, and distributing accident and health insurance policies in a constant stream of commerce, as "commerce" is defined in the Federal Trade Commission Act, from the State of Illinois to purchasers thereof located in states other than the State of Illinois. Respondent's premium income from its sale of accident and health insurance policies for the years 1953, 1954, and 1955, was \$10,014,811.94, \$10,555,298.43, and \$12,134,260.16, respectively. In 1953 respondent had approximately 1,000,000 policy holders located throughout the United States, with the number increasing at the rate of five percent in 1954 and five percent in 1955. Respondent does a nation-wide business and operates entirely through an agency system composed of 2,200 agents located in all states of the United States and the District of Columbia, of which 90 are general agents.

4. In the course and conduct of its business, respondent, for the purpose of selling its accident and health policies, has disseminated in commerce advertising relating to its policies by means of newspapers, magazines, mail letters, circulars, and radio throughout the nation. Its agents are under contract with respondent and they themselves prepare and disseminate some of the advertising of the policies they sell, such advertising having to be approved by the home office of respondent in Chicago. Ninety-five percent of the advertising is prepared by the home office staff and furnished to the agent. This advertising obviously plays an important part in the sale of policies. In some instances agencies mail out prospect-locating devices to persons listed in telephone directories. Respondent's agent located in Newark, New Jersey, advertises by radio commercials and in newspapers and magazines upon a nation-wide basis.

5. Some of respondent's policies are sold by its agents by personal contact and solicitation, which result in the procurement of a written application which is forwarded to the home office, where the policy is issued and returned to the agent for delivery to the insured. Respondent's agent in Newark, however, solicits and sells respondent's policies by mail to persons located throughout the

United States. Newspaper and magazine advertising contains a coupon and the prospect, if interested, clips and sends it to the agent. These coupons are received by the respondent's Newark agent from prospects located in all 48 states. Radio commercials urge the interested prospect to contact that agent by mail and, when this occurs, such agent mails to the prospect a letter and application for the policy. If the prospect does not return the completed application, the agent mails out follow-up material. When respondent's Newark agent receives the completed application, he issues a policy to the purchaser and there is, therefore, no personal contact between respondent's Newark agent and purchaser. The policy is countersigned by the agent licensed in the state in which the purchaser resides, but the Newark agent is also licensed in every state. Respondent's home office, however, exercises veto power over any policy issued by an agent.

6. In the course and conduct of its said business, and for the purpose of inducing members of the public to become insured by respondent under the terms and provisions of the policies advertised, respondent has made, and is now making, numerous statements and representations concerning the benefits provided in its said policies of insurance by means of newspaper advertisements, radio commercials, circulars, and other advertising material disseminated between and among the various states of the United States. Typical, but not all inclusive, of said statements and representations, are the following:

1. With respect to the duration of coverage, provided by the Series 500 Policy—

MEN AND WOMEN HAIL NEW KIND OF
SICKNESS AND ACCIDENT POLICY.
NO REDUCTION IN BENEFITS REGARDLESS OF AGE

* * * * *

The older you are, the harder it is to get protection against financial worries that come when accident or sickness strikes. That's why the reliable North American Accident Insurance Company of Chicago has issued a special policy for men or women up to 75 years of age. * * *

If your policy is in effect at age 75, you may even continue it to age 80 at no further increase in premium. ABSOLUTELY NO REDUCTION IN BENEFITS REGARDLESS OF AGE.

NOW—SECURITY FOR OLDER PEOPLE TOO
Needed Protection for Men and Women Up
to Age 75

No longer need accidents or sickness mean dependence on friends or relatives when you're older. For now, with this new protection, you can be sure of cash assistance when you need it most! Sure that your benefits will not be reduced because of advanced age. * * *

NO REDUCTION IN BENEFITS BECAUSE OF ADVANCED AGE.

The Older You Are the More You Need This Policy.

MEN AND WOMEN FROM AGES 15 to 75 NOW COVERED.

2. With respect to the health status of prospective policyholders of the Series 500 Policy—

**NO MEDICAL EXAMINATION IS NECESSARY—MERELY
YOUR OWN STATEMENT AS TO YOUR PRESENT HEALTH.**

No medical examination is necessary.—

Counsel supporting the complaint contends that these representations give the prospect the impression that solely by prompt payment of premiums he or she can keep the indemnity in force until age 75 or 80, whereas the policy itself provides that it is terminable at any premium date by respondent for any reason, or no reason at all, and further that these above representations give the impression that the physical condition of the prospect is immaterial as of the date of the application, whereas the terms of the policy exclude payments for losses resulting from sickness or disease, the cause of which is traceable to a condition existing prior to or within thirty days from the effective date of the policy.

7. Counsel for respondent insists the above excerpts are unfairly lifted from context and that a reading of the entire advertisement gives no misleading impression. This the hearing examiner has done and is of the opinion, and so finds, that the representations made do give the impression contended for by counsel supporting the complaint.

8. Duration of coverage and physical condition are highly important to prospects, particularly those of middle age or older. Respondent's advertising here and its representations, compared with the policies issued thereafter, are substantially the same as those involved in D. 6311, National Casualty Company, which this hearing examiner, and subsequently on appeal, the Commission, found to be misleading and deceptive, and the same finding is made here.

9. Statements disseminated by the respondent in its advertising for the purpose of promoting sales in commerce of its "Series 500" Limited Accident and Sickness Policy have included the following:

The "Series 500" Policy Pays Accidental Death, Dismemberment—and Hospitalization Benefit—for common accidents that happen every day—at home, at work, at recreation, etc. Pays liberal Weekly Benefit for 21 common—and serious sicknesses that might take you away from work for weeks or months.

10. Through use of the foregoing statements and representations and others of similar import and meaning, the respondent has represented, directly and by implication, that cash benefits are paid in

all instances wherein death, dismemberment and hospitalization result from the types of common accidents enumerated in the policy; and that the respondent's said policy provides indemnification in the form of weekly benefits for 21 common illnesses which might prevent the insured from working.

11. Contrary to the representations contained in the advertising, however, the respondent's policies do not provide benefits for death or dismemberment and hospitalization in all situations where loss of life, limb or sight or hospitalization results from accidents to which the policies relate. Its contracts of insurance instead provide for payment of cash benefits for losses resulting in death and dismemberment only when caused by accidental bodily injury not excluded by other provisions of the policies, and when such injury, from date of the accident, causes total and continuous disability and results in loss of life, limb or sight within 30 days from the date of the accident. Furthermore, only one amount is payable, if at all, as a result of one accident and the occurrence of any such loss terminates the insurance effected by the policy. The hospitalization benefits described in the advertising as provided when total disability results from accidents there designated are payable only if resultant disability is immediate and confinement in the hospital similarly immediate.

The existence of the foregoing restrictions and limitations on the indemnification afforded under the policies has not been disclosed in the respondent's promotional matter. The Commission accordingly concludes, and so finds, that the promises in the advertising relating to benefits afforded under the policies to insureds suffering death or dismemberment or incurring hospitalization as a result of accidental bodily injury are false, misleading and deceptive.

12. Nor is it true that the respondent's policies necessarily provide indemnification for disability or loss of time caused by 21 common sicknesses. Such benefits will not be paid by the respondent if the cause of such sicknesses is traceable to a condition existing prior to or within 30 days after the effective date of the policy. While the advertisement descriptive of sickness benefits which contains the second quoted excerpt appearing in Paragraph 9 hereof elsewhere states that benefits are limited to the period of disability succeeding the seventh day of confinement and attended by the inability to work and confinement within home or hospital under care of a physician, the policy additionally provides that the stipulated total disability and confinement must be continuous disability and confinement if the insured is to be eligible for benefits. This limitation

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and the policy's exclusion in reference to illnesses caused by pre-existing conditions are not disclosed in the advertising. The Commission therefore finds that the respondent's advertising representations relating to indemnification accorded for sicknesses are false, misleading and deceptive.

13. The fifth and last charge of misrepresentation is founded on respondent's representation

All sicknesses covered except venereal

whereas the policy issued pursuant to this solicitation excludes any sickness the cause of which is traceable to a condition existing prior to or within thirty days from the effective date of the application. Respondent contends that the phrase "benefits effective 30 days from date of policy" cures any misconception, but certainly this language does not reach a condition pre-existing to issuance. The representation is absolute and unqualified. It is highly material to the prospect and, although he is told he cannot collect for thirty days, he is nowhere told that he may not collect if his illness is caused by any condition existing before that time. The finding is that this representation is misleading and deceptive.

14. Respondent offers two defenses to this proceeding—abandonment or cessation, and lack of jurisdiction. The record shows that much of the advertising on which this proceeding is brought was revised or discontinued in November 1954, and March 1955, and respondent's executives have testified none of it will be resumed while they are in control.

15. Dismissal on this basis is discretionary with the Commission under all the facts, the criterion being probability of resumption. As the guardian of the public interest, the Commission must feel assured, after it has spent tax funds to uncover and prove violation, that such will not reoccur, with the whole process having to be repeated. Considerations which have been deemed controlling in dismissals in other cases, such as the discontinuance of the production or sale of the product misrepresented, sale of that part of its business to others, economic or commercial changes forced on the respondent by trade conditions, cessation of business entirely, are not present here.

16. Some of the statements found to be misrepresentative and misleading in paragraphs 6, 7, 8, and 13 above, are still being used—the 1954 revisions did not eliminate these. Good faith in the discontinuance is therefore not established. While the revisions and some of the discontinuances did take place prior to the issuance of the complaint in November 1955, they were after respondent knew

that the Commission was inquiring into its advertising practices and those of other insurance companies. The hearing examiner has no doubt of the candor of respondent's officials who testified that resumption would not occur while they are in charge of respondent, but there is of course no guarantee of their tenure of office, nor that their successors will follow their policies. Lastly, respondent still contends that none of its advertising is misleading or deceptive, hence there is no moral block, at least to its resumption. To this examiner, absolution presumes confession, if not penance. Here we have not only a claimed absence of sin, but a denial of authority to determine sin or grant the absolution. On the whole, the hearing examiner is of the opinion that the public interest requires the issuance of the order which follows, to insure against resumption of violation.

17. Respondent's second defense is that by reason of the provisions of the McCarran Act (15 U.S.C. 1011-15), the regulation of respondent's business is in the hands of the states, and the Federal Trade Commission is without jurisdiction in this proceeding. Respondent's counsel has briefed this point at great length, but in view of the Commission's decisions in Docket 6237, American Hospital & Life Insurance Company, and in Docket 6311, National Casualty Company, squarely holding that it has full and complete jurisdiction of the subject matter, regardless of the McCarran Act, no useful purpose is served here by reviewing and discussing the point or the many decisions cited on respondent's brief, since the same contentions are being made here. The hearing examiner is bound by those two decisions and accordingly rules in consonance therewith.

CONCLUSIONS OF LAW

1. The Federal Trade Commission has full jurisdiction of this proceeding.
2. The public interest in which this proceeding is brought is clear and substantial.
3. Actual deception need not be shown, tendency or capacity thereto, from the representations made, being sufficient.
4. The law under which this proceeding is brought is violated if the first contact or interview is secured by deception even though the true facts are made known to the buyer before he enters into the contract of purchase.
5. The use by respondent of the statements and representations, as found herein and in Paragraphs 6 through 8 and in Paragraph 13 of the initial decision to be deceptive and misleading, as they

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relate to the terms and conditions of its policies of insurance, and the failure by the respondent to reveal the limitations of the coverage of said policies, have 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 unqualifiedly true and to induce the purchase of said policies of insurance because of such erroneous and mistaken belief.

6. The representations made by respondent, hereinabove found to be deceptive and misleading, have been to the prejudice and injury of the public and constitute unfair and deceptive acts and practices within the meaning of the Federal Trade Commission Act.

ORDER

It is ordered, That respondent, North American Accident Insurance 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, medical, 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, at, or after issuance of the policy; or otherwise representing that the condition of the insured's health at the time of the 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 indemnification against disability or loss due to sickness or accidental injury unless a statement of all the conditions, exemptions, 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 OF THE COMMISSION

By KERN, Commissioner:

The respondent issues and sells accident and health insurance policies to insureds located throughout the United States and is charged in this proceeding with misrepresenting its policies' benefits and coverage in violation of the Federal Trade Commission Act. The case is presented for determination upon the cross-appeals filed by the respondent and counsel supporting the complaint from the initial decision of the hearing examiner which held that certain of the allegations of the complaint were sustained by the greater weight of the evidence and ruled others not so supported.

Respondent, North American Accident Insurance Company, is an Illinois corporation and its principal place of business is in Chicago. Distribution of its policies is effected through an agency system composed of 2,200 agents located throughout the United States, the company being licensed to conduct business in each of the 48 States. Media used in soliciting interstate sales of policies to prospective purchasers include newspapers, mailing circulars and radio. One of its authorized agents, located in Newark, New Jersey, also engages in the nation-wide advertising and sale of the respondent's policies.

Under the terms of the respondent's accident and health policies the contracts are terminable at its option at any premium date. In the course of offering a designated policy series as a new kind of policy and a special contract for insureds up to 75 years of age, advertising therefor has included the statement "No reduction in benefits regardless of age." The first error assigned under the respondent's appeal pertains to the initial decision's holding that such statement has served to represent that its policies may be continued in effect at the option of the insured upon payment of premiums within times and in amounts provided by the policy. The respondent's advertising also has emphasized that security is afforded under the policy for older people, together with certainty of cash assistance when needed most. In this setting, assurances contained in the advertising against reductions in promised benefits by reason of age clearly suggest and imply that the insured's policy protection likewise may be continued at his option. Hence, we conclude that the hearing examiner was correct in holding that the respondent has falsely represented that its policies may be kept in force continuously at the option of the insured.

The respondent's second objection relates to certain of the initial decision's rulings which sustain the complaint's charges challenging, as false and misleading, the statement in the advertising that no

medical examination is necessary. Although examination by a physician is not required prior to issuance of a policy, the company by the terms of many of its contracts reserves the right to examine the person of the insured as often as it may reasonably require during the pendency of any claim under the policy. We concur in the hearing examiner's conclusion that, when construed in the context in which it has appeared 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 the effective date of the policy when determining eligibility for benefits thereunder. As found in the initial decision, however, benefits are not payable under the respondent's policies for losses resulting from sickness in case its cause is traceable to a condition existing prior to or within 30 days from the date of the policy. Proffered waivers pertaining to medical and health requirements are highly material matters to prospective insureds and erroneous impressions necessarily will result unless they contain full and complete disclosure of any limitations inherent therein. This aspect of the respondent's appeal is without merit.

In an advertising pamphlet which the respondent has furnished for use by its agents in reference to one of its insurance contracts, the statement is made that all sicknesses are covered except venereal. Because the policy has specifically provided that no benefits are payable for any loss the cause of which is traceable to a condition existing prior to or within 30 days after the date of the policy, the hearing examiner found the foregoing representation of coverage to be false. In arguing that he erred thereby, the respondent states that any capacity to deceive inherent in the statement necessarily is eliminated through the advertisement's accompanying statement of "benefits effective 30 days from date of policy." This, the appeal asserts, clearly reveals that preexisting illnesses are excluded. While the statement in regard to benefits not being effective for 30 days may place insureds on notice that no payments will be afforded prior to 30 days after the date of the policy, it is obvious that the prospect is not informed that he cannot collect for loss of time subsequent thereto if the sickness or disease from which it stems originated at some time prior to such effective date. The respondent's contention of error in that regard by the hearing examiner is being rejected. Prospective purchasers of the respondent's policies are entitled to rely on the sales representations made and are under no obligation to investigate the extent to which unrestricted repre-

sentations of coverage for sickness may be untrue.

Dismissal of this proceeding is requested on grounds that the respondent's insurance business is regulated by the states in which it does business and that jurisdiction over its practices is barred by the provisions of the McCarran-Ferguson Act (Public Law 15, 79th Cong., 15 U.S.C.A., § 1011-15). 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 examiner correctly found that the Commission had jurisdiction over such of the respondent's practices in interstate commerce as might be found to be unfair and deceptive.

Considered also have been the matters urged in support of the respondent's contentions that the practices complained of have been abandoned, that there is no probability of their resumption and that public interest accordingly is lacking in this proceeding. The respondent's discontinuance of certain of the practices challenged in the complaint occurred subsequent to institution of this proceeding; and not all of the practices in the vein challenged in the complaint have been discontinued. In these circumstances, the Commission has concluded that issuance of an appropriate order to cease and desist is required in the public interest. The respondent's appeal is denied accordingly.

Before proceeding to a discussion of points presented under the appeal of counsel supporting the complaint, reference is made to the respondent's contention that such appeal should be dismissed for the reason that notice of intention to appeal was not filed within 10 days after service of the initial decision, as prescribed under § 3.22 of the Commission's Rules of Practice. The initial decision was filed on August 13, 1956, and the service card in the official record attests that service thereof upon staff counsel was made on Friday, August 17, 1956, by the Office of the Assistant Secretary for legal and Public Records. Counsel's notice of intention to appeal was filed on August 28, 1956. Under § 3.5 of the Commission's Rules, computation of any period of time prescribed or allowed under such rules begins with the first business day following the act initiating such period of time (service of the initial decision in this instance), and the time prescribed for filing of notice of intention to appeal began running on August 20, 1956. It is thus evident that notice of intention to appeal was duly filed within the time prescribed by rule; and the respondent's contention of untimely submission is accordingly rejected.

Counsel supporting the complaint has appealed from the hearing examiner's holdings dismissing those charges of the complaint relevant to its allegations that the respondent has misrepresented the extent of coverages afforded by its Series 500 policies for death, dismemberment and hospitalization caused by accidents and for disability from sicknesses. We think that the hearing examiner clearly erred in failing to conclude that the advertising statements utilized by the respondent in promoting the interstate sales of its policies have constituted representations that benefits are paid in all instances wherein death, dismemberment and hospitalization result from the types of common accidents enumerated in the policy. The benefits actually provided under the terms of the policies represent substantial and material departures from those promised in the advertisements. In addition to other exclusions stipulated thereunder, such contracts provide for payment of benefits for losses resulting in death and dismemberment from listed accidents only when the insured's injury, from the date of the accident, causes total and continuous disability and when loss of life, limb or sight results within 30 days from the date of accident.

Furthermore, the hospitalization benefits, which the advertising represents are provided for total disability caused by accidental bodily injuries, are payable only when resultant disability is immediate and confinement in the hospital similarly immediate. The existence of the foregoing restrictions and limitations as to indemnifications actually afforded under its policies for accidental injuries and attendant hospitalization has not been disclosed in the respondent's promotional material. We accordingly are of the view that the advertising has misrepresented the policies' coverage with respect to death, dismemberment and hospitalization benefits and that such misrepresentations have had the capacity and tendency to deceive.

Capacity and tendency to mislead and deceive similarly has inhered in the advertising statements offering benefits for sickness, inasmuch as the advertising has failed to disclose the exclusion from coverage under the policies of sicknesses traceable to conditions existing prior to the effective date of such policies and that losses are excluded when total disability and confinement to home or hospital is not continuous. The hearing examiner erred in not so finding.

The appeal of counsel supporting the complaint is granted and the respondent's appeal denied. The initial decision is being modified in conformity with this opinion.

Commissioners Gwynne and Tait dissented.

DISSENTING OPINION

By TAIT, Commissioner:

Respondent, an Illinois corporation, with its principal place of business in Chicago, is engaged in the business of selling accident and health insurance in interstate commerce and is licensed to conduct such business in each of the 48 states and in the District of Columbia. The business is conducted through an agency system composed of agents located in all the states and the District of Columbia. One of respondent's authorized agents, located at Newark, N.J., is likewise licensed to do business in every state and also solicits and sells policies by mail. Respondent's home office in all instances has veto power over any policy issued by an agent.

Generally speaking, respondent and its Newark agent in the course of business disseminate advertisements relating to respondent's policies throughout the nation by means of newspapers, magazines, letters, circulars and radio.

It is respondent's advertising practices which are challenged by the Commission's complaint as a violation of Section 5 of the Federal Trade Commission Act. The respondent contends that this Commission has no jurisdiction over these practices because of the McCarran-Ferguson Act.¹

It would seem unnecessary to repeat the Commission's thorough analysis of the foregoing Act in the *American Hospital* case² wherein the majority held that this Commission had jurisdiction over the questioned advertising practices of the American Hospital & Life Insurance Company. The conclusions of the minority was that, under the facts of the case, the respondent's advertising was "regulated by state law" and the Commission was, therefore, without jurisdiction.

Prior to 1944 when the Supreme Court rendered its decision in *United States v. South-Eastern Underwriters Association*,³ the business of insurance was not considered to be in interstate commerce. Insurance had always been, over the years, a business—a subject—regulated by the several states. The *South-Eastern Underwriters* decision, however, held the business of insurance to be in interstate commerce, thereby bringing the business within the full sweep of the Commerce Clause, with all of its concomitants of federal regulation.

¹Public Law 15, 79th Congress (15 U.S.C.A., § 1011-15).

²*In the Matter of American Hospital & Life Insurance Company*, Docket No. 6237.

³322 U.S. 533 (1944).

Almost immediately upon the heels of this Supreme Court decision, Congress passed the McCarran-Ferguson Act in 1945. The Act reads:

An Act to express the intent of the Congress with reference to the regulation of the business of insurance.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

SEC. 2. (a) 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.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

SEC. 3. (a) Until June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, and the Act of June 19, 1936, known as the Robinson-Patman Antidiscrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this Act shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

SEC. 4. Nothing contained in this Act shall be construed to affect in any manner the application to the business of insurance of the Act of July 5, 1935, as amended, known as the National Labor Relations Act, or the Act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938, or the Act of June 5, 1920, known as the Merchant Marine Act, 1920.

SEC. 5. As used in this Act, the term "State" includes the several States, Alaska, Hawaii, Puerto Rico, and the District of Columbia.

SEC. 6. If any provision of this Act, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected.

In the enacting clause Congress expressed itself clearly that the continued regulation of insurance by the several states is in the public interest. Congress also declared that silence on its part was not to be construed as imposing any barrier to regulation by the several states. A more clear and forceful expression of Congressional intent

than that written into this Act is difficult to imagine. In Section 2 (a), Congress further said: "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." [Emphasis added.] Congress was aware of the activity across state lines in which most insurers engage and which automatically places them in the category of an insurer engaged in interstate commerce. Congress was equally aware of the inevitable non-uniformity of regulation and taxation by the *several* states.⁴

Having thus expressed its over-all policy with respect to continued state regulation and taxation, followed by the positive declaration that the business of insurance shall be subject to the several states' regulation and taxation, Congress then carefully marked out certain exceptions and limitations with respect to the application of federal statutes. It dealt with the Federal Trade Commission Act in two respects: a three-year moratorium was granted during which the Federal Trade Commission Act was not to apply to the business of insurance at all;⁵ after the moratory period, the Federal Trade Commission Act was to apply to the extent that such business was not regulated by state law.⁶ It dealt similarly with the Sherman and Clayton Acts, with one specific exception—that nothing contained in the McCarran-Ferguson Act was to render the Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.⁷ And finally, Congress stated explicitly that nothing contained in the Act was to be construed "to affect in any manner" the application of the National Labor Relations Act, the Fair Labor Standards Act, or the Merchant Marine Act to the business of insurance.⁸ Thus federal jurisdiction over the business of insurance was limited precisely to the areas reserved.

In the exercise of plenary power over interstate commerce, Congress can authorize or permit a state to regulate within its boundaries a subject-matter or practice whether or not such regulation would otherwise constitute state regulation of interstate commerce, would burden interstate commerce, or would even affect interstate commerce outside the state's jurisdictional boundaries. [*Southern Pacific Company v. Arizona*, 325 U.S. 761 (1945); *Prudential Insurance Company v. Benjamin*, 328 U.S. 408 (1946); *Kentucky Whip and Collar Co. v. Illinois Central Railroad Company*, 299 U.S. 334

⁴Cf. *Prudential Insurance Company v. Benjamin*, 328 U.S. 408 (1946).

⁵Section 3(a) of the McCarran-Ferguson Act.

⁶Section 2(b).

⁷Section 3(b).

⁸Section 4.

(1937); *Wilburn Boat Company v. Firemen's Fund Insurance Co.*, 348 U.S. 310 (1955); *International Shoe Company v. Washington*, 326 U.S. 310 (1945); and *South Carolina State Highway Department v. Barnwell Brothers, Inc.*, 303 U.S. 177 (1938).]

Under our system of government certain powers have been distributed between the federal government and the states. The Courts have often invalidated state regulation which is designed to accomplish the same results as a federal statute. *Hines v. Davidowitz*, 312 U.S. 52 (1941). In *Charleston & W. C. Ry. v. Varnville Furniture Co.*, 237 U.S. 597 (1915), Justice Holmes said:

When Congress has taken the particular subject-matter in hand coincidence is as ineffective as opposition, and a state law is not to be declared a help because it attempts to go farther than Congress has seen fit to go.

Unless sanctioned by Congress, joint or concurrent regulation is repugnant to our federal-state governmental philosophy because of the tremendous burden imposed upon those subject to dual regulation. On this theory state statutes have been struck down. Conversely, when Congress in effect says to the states, "It is in the public interest that you should regulate this industry," it is unsound to presume that Congress intended joint or concurrent federal and state regulation. In the McCarran-Ferguson Act it is clear that the states can regulate insurance advertising. It is not clear that both the federal government and the states can jointly regulate. Because of the unnecessary burden imposed on those regulated, a clearer expression of Congressional intent should be required to hold that there is joint federal-state regulation, which seems to be the Commission's majority view. Here we have no indication of such an intent. In fact, the Act itself refutes any such contention.

If, as an end result, the states enact laws regulating the advertising practices of the insurer, and if the insurer is subject to the jurisdiction of each such state,⁹ then the practice is regulated by state law; and this Commission is without jurisdiction. If the insurer is not subject to the jurisdiction of a state, then despite the existence of regulatory statutes, advertising disseminated therein would not be subject to state regulation.¹⁰ In this latter event, the Federal Trade Commission Act would apply to the advertising practice, for "to [that] extent * * * such business is not regulated by state law."

Nor have we as yet found reason or authority to alter these views

⁹E.g., licensed within the state or otherwise within reach of the state's police power. Cf. *Travelers Health Association v. Virginia*, 339 U.S. 643 (1950); *International Shoe Company v. Washington*, 326 U.S. 310 (1945); *Hoopeston Canning Co. v. Cullen*, 318 U.S. 313 (1943); and *Prudential Insurance Company v. Benjamin*, 328 U.S. 408 (1946).

¹⁰Cf. concurring opinion of Chairman Gwynne, *In the Matter of Travelers Health Association*, Docket No. 6252.

merely because certain advertising of respondent insurer was disseminated through the media of the mails and radio. These circumstances, however, do present somewhat novel questions of law.

We recognize that Congress has occupied the field of radio regulation and that such medium is not subject to regulation by the states.¹¹ We recognize also that the federal government has exclusive jurisdiction over the regulation of the United States mails.¹²

It might be argued, however, that in neither instance of radio or mail dissemination would the state's action be an attempt to regulate the *media*. Rather, the state action might be held to constitute regulation of the business of insurance—more specifically, the advertising practices of the insurer. By way of analogy we have found no case holding that Commission proceedings against any respondent for use of false and deceptive advertising—whether dissemination is by mail, by radio and TV, by newspapers or by national magazines—constitutes regulation of the *media* used in dissemination. In this respect, a Commission proceeding might not differ from that of a state agency, viz., neither agency is regulating or attempting to regulate the media but rather is regulating a business practice of an advertiser.

In the matter now before us, the hearing examiner made no determination as to whether each one of the 49 jurisdictions wherein this respondent is licensed to do business has enacted the so-called "Model Code," or comparable legislation, to regulate the advertising practices of insurers. Nor do we know to which type of insurer (life or health and accident) the existing statutes may apply. Under the majority opinion in *American Hospital*, the hearing examiner was not required to resolve these questions.

We would, therefore, remand this proceeding to the hearing examiner to resolve the foregoing questions and to allow counsel for both sides the opportunity to brief the novel issues relating to state regulation of insurance advertising disseminated by mail and radio.

Chairman Gwynne concurs in this dissent.

FINAL ORDER

Counsel in support of the complaint and counsel for the respondent, North American Accident Insurance 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

¹¹Cf. *Allen B. Dumont Laboratories, Inc., v. Carroll*, 184 F. 2d 153 (1950), cert. denied, 340 U.S. 929 (1951).

¹²*United States v. Sylvanus*, 192 F. 2d 96 (1951), cert. denied, 342 U.S. 943 (1952).

its decision granting the appeal of counsel supporting 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 9 to 12, inclusive, of the findings as to the facts contained in the initial decision:

"9. Statements disseminated by the respondent in its advertising for the purpose of promoting sales in commerce of its 'Series 500' Limited Accident and Sickness Policy have included the following: The 'Series 500' Policy Pays Accidental Death, Dismemberment—and Hospitalization Benefit—for common accidents that happen every day—at home, at work, at recreation, etc. Pays liberal Weekly Benefit for 21 common—and serious sicknesses that might take you away from work for weeks or months.

"10. Through use of the foregoing statements and representations and others of similar import and meaning, the respondent has represented, directly and by implication, that cash benefits are paid in all instances wherein death, dismemberment and hospitalization result from the types of common accidents enumerated in the policy; and that the respondent's said policy provides indemnification in the form of weekly benefits for 21 common illnesses which might prevent the insured from working.

"11. Contrary to the representations contained in the advertising, however, the respondent's policies do not provide benefits for death or dismemberment and hospitalization in all situations where loss of life, limb or sight or hospitalization results from accidents to which the policies relate. Its contracts of insurance instead provide for payment of cash benefits for losses resulting in death and dismemberment only when caused by accidental bodily injury not excluded by other provisions of the policies, and when such injury, from date of the accident, causes total and continuous disability and results in loss of life, limb or sight within 30 days from the date of the accident. Furthermore, only one amount is payable, if at all, as a result of one accident and the occurrence of any such loss terminates the insurance effected by the policy. The hospitalization benefits described in the advertising as provided when total disability results from accidents there designated are payable only if resultant disability is immediate and confinement in the hospital similarly immediate.

"The existence of the foregoing restrictions and limitations on the indemnification afforded under the policies has not been disclosed in the respondent's promotional matter. The Commission accordingly concludes, and so finds, that the promises in the advertising relating to benefits afforded under the policies to insureds suffering death or

dismemberment or incurring hospitalization as a result of accidental bodily injury are false, misleading and deceptive.

"12. Nor is it true that the respondent's policies necessarily provide indemnification for disability or loss of time caused by 21 common sicknesses. Such benefits will not be paid by the respondent if the cause of such sickness is traceable to a condition existing prior to or within 30 days after the effective date of the policy. While the advertisement descriptive of sickness benefits which contains the second quoted excerpt appearing in Paragraph 9 hereof elsewhere states that benefits are limited to the period of disability succeeding the seventh day of confinement and attended by the inability to work and confinement within home or hospital under care of a physician, the policy additionally provides that the stipulated total disability and confinement must be continuous disability and confinement if the insured is to be eligible for benefits. This limitation and the policy's exclusion in reference to illnesses caused by preexisting conditions are not disclosed in the advertising. The Commission therefore finds that the respondent's advertising representations relating to indemnification accorded for sickness are false, misleading and deceptive."

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

1. The Federal Trade Commission has full jurisdiction of this proceeding.
2. The public interest in which this proceeding is brought is clear and substantial.
3. Actual deception need not be shown, tendency or capacity thereto, from the representations made, being sufficient.
4. The law under which this proceeding is brought is violated if the first contact or interview is secured by deception even though the true facts are made known to the buyer before he enters into the contract of purchase.
5. The use by respondent of the statements and representations, as found herein and in Paragraphs 6 through 8 and in Paragraph 13 of the initial decision to be deceptive and misleading, as they relate to the terms and conditions of its policies of insurance, and the failure by the respondent to reveal the limitations of the coverage of said policies, have 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 unqualifiedly true and to induce the purchase of said policies of insurance because of such erroneous and mistaken belief.

6. The representations made by respondent, hereinabove found to be deceptive and misleading, have been to the prejudice and injury of the public and constitute unfair and deceptive acts and practices within the 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, North American Accident Insurance 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, medical, 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, at, or after issuance of the policy; or otherwise representing that the condition of the insured's health at the time of the 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 indemnification against disability or loss due to sickness or accidental injury unless a statement of all the conditions, exemptions, 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, North American Accident Insurance 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 with the order to cease and desist.

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

Decision

IN THE MATTER OF
ARROW METAL PRODUCTS CORPORATION ET AL.

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

Docket 6471. Complaint, Nov. 21, 1955—Decision, Feb. 20, 1957

Order requiring two manufacturers, with places of business at Haskell and Wayne, N.J., respectively, to cease using the term "Porcenamel" to describe the organic plastic resin finish or coating of their metal awnings, component parts for metal awnings, or enamel-coated metal strips and pieces.

Terral A. Jordan, Esq., for the Commission.

Gurtman & Schomer, by *William N. Gurtman*, Esq., of Passaic, N.J., for respondents.

INITIAL DECISION BY ROBERT L. PIPER, HEARING EXAMINER

STATEMENT OF THE CASE

On November 21, 1955, the Federal Trade Commission issued its complaint against Arrow Metal Products Corporation, Awnair Corporation of America, and Alex Levine, James V. Cosman and Wm. N. Gurtman, individually, and as officers of both corporations (all hereinafter collectively referred to as respondents), charging them with the use of unfair methods of competition and unfair and deceptive acts and practices in commerce in violation of Section 5 of the Federal Trade Commission Act (hereinafter called the Act), 15 U.S.C. 41, *et seq.* Copies of said complaint together with a notice of hearing were duly served upon respondents.

The complaint alleges in substance that respondents, through the use of the name "Porcenamel" to describe the finish of their products, falsely represented that such products were finished with porcelain enamel. Respondents appeared by counsel and filed a joint answer admitting the corporate, commerce and competition allegations of the complaint, but denying the alleged violation of the Act.

Pursuant to notice, hearings were thereafter held on January 25, January 27, and March 23 in New York City and Washington, D.C., before the undersigned hearing examiner, duly designated by the Commission to hear this proceeding. Prior to the initial hearing, counsel supporting the complaint filed a motion requesting that official notice be taken concerning the meaning and usage of the words "porcelain enamel." In support thereof, counsel supporting