

IN THE MATTER OF
AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY

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

Docket 6238. Complaint, Oct. 14, 1954—Decision, Apr. 19, 1957

Order requiring a St. Louis, Mo., insurance company to cease misrepresenting the renewability and duration, indemnification for surgical expenses, and extent of accident and sickness coverage of its "accident and health" or "hospital and surgical" insurance policies, in advertising which failed to make adequate disclosure of exceptions to the coverage afforded by the policies.

Mr. Francis C. Mayer and *Mr. P. R. Melangton, Jr.* for the Commission.

Mr. A. Alvis Layne, Jr., and *Mr. T. S. L. Perlman*, of Washington, D.C., for respondent.

INITIAL DECISION BY J. EARL COX, HEARING EXAMINER

The respondent is charged with violating the Federal Trade Commission Act, as that Act is applicable to the business of insurance under the provisions of Public Law 15, 79th Congress (Title 15, U.S. Code, Sections 1011 to 1015, inclusive), through the dissemination of false and misleading advertising relating to accident, health, hospital and surgical insurance policies which have been sold in commerce by respondent. This charge is denied. In its answer respondent has also alleged specifically (a) that it is not engaged in commerce as that term is defined in the Federal Trade Commission Act, and (b) that its business is regulated by state law and hence the Federal Trade Commission Act is not applicable to respondent or its business. Further, respondent has set forth in its answer a summary of its past dealings with the Commission, both prior and subsequent to the promulgation in 1950 of the Commission's Trade Practice Rules Relating to the Advertising and Sales Promotion of Mail Order Insurance, alleging that respondent

1. applied for and actively participated in the conference at which such proposed rules were considered;

2. signed said rules and subsequently attempted to cooperate with the Commission by submitting its policies and advertising materials to members of the Commission's staff for consideration and approval, and that respondent was informed that such materials were not objectionable;

3. applied in 1952 for a further conference to enlarge, clarify and amend the Trade Practice Rules; and

4. cooperated with the Commission in its general investigation, instituted in 1953, of advertising practices in the accident and health insurance industry, and repeatedly assured the Federal Trade Commission that it desired to cooperate in the elimination of any advertising practices considered unfair or deceptive.

A motion filed prior to hearing, that the complaint be dismissed for lack of jurisdiction or that the matter be referred to the Commission's Bureau of Consultation, was denied by the Hearing Examiner. A motion also filed prior to hearing, to dismiss on the basis of respondent's prior course of dealing with the Commission and its staff, or in the alternative that the issues pertaining to such prior course of dealing be severed and heard separately from the other issues, was certified to the Commission, which denied the motion, without argument, in its entirety "but without prejudice to respondent's right to renew said request (for a separation of issues and hearing) to the Hearing Examiner".

Thereafter hearings were held, at which evidence in support of and in opposition to the allegations of the complaint was received, duly recorded and later filed in the office of the Commission.

At the close of the case-in-chief in support of the complaint, and before the presentation of any evidence in opposition thereto, respondent moved again to dismiss the complaint for lack of jurisdiction and on the ground that insufficient evidence had been presented to establish that respondent has engaged in unfair or deceptive acts and practices. Both requests were denied—the first on a ruling that the Federal Trade Commission does have jurisdiction over respondent as to the matter at issue in this proceeding; and second on a finding that sufficient evidence had been introduced to establish a *prima facie* case. Proposed findings of fact and conclusions of law have been submitted. Upon the basis of the entire record the following findings and conclusions are made.

I. JURISDICTION

The first issue to be determined is that of jurisdiction. Respondent is a corporation organized and doing business under the laws of the State of Missouri, with its home office at 3805 Lindell Boulevard, in St. Louis. It is licensed in Missouri to engage in life, health and accident insurance business. It has a number of district agency offices in Missouri, but no offices or agents outside Missouri, and is not licensed in any other state. It prepares advertising, mails

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advertising material, issues policies, passes on applications and claims, and takes all other action at its home office. Its advertising material is mailed to prospective customers living in states other than Missouri. It also uses radio advertising, which reaches beyond the boundaries of Missouri. During 1953 and 1954 respondent sold and issued policies to residents of each of the 48 states and the District of Columbia. In 1953 its accident and health premium receipts were \$380,826, of which \$147,654 came from policy-holders living elsewhere than in Missouri; in 1954 accident and health premium receipts were \$326,710, of which \$125,793 was from non-residents of Missouri. Its business in commerce is substantial.

In its decision in *United States v. South Eastern Underwriters Association*, 322 U.S. 533 (1944), the Supreme Court held that insurance business, unless confined to a single state, is commerce as the term "commerce" is used in the Constitution, the antitrust laws and the Federal Trade Commission Act. Prior to that time regulation and control of insurance had been exclusively by the states. Following this decision, considerable unrest and uncertainty developed in the insurance industry and among officials of the insurance departments of the various states, which Congress undertook to allay by passing the McCarran Act (Public Law 15, 59 Stat. 33, as amended, 61 Stat. 448, 15 U.S.C. 1011-1015), the pertinent provisions of which read as follows:

§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.

§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 Anti-discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

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

Particularly in question in this proceeding is the language of the proviso clause of Section 2(b), which states that the Federal Trade

Commission Act, under which this proceeding is brought, "shall be applicable to the business of insurance to the extent that such business is not regulated by State law". Had there been no Public Law 15, it is agreed that the Federal Trade Commission Act would have been applicable to the business of insurance in the same manner and to the same extent as it is applicable to other business in interstate commerce, and the precedents of the numerous court decisions on the question of Federal Trade Commission jurisdiction would have been controlling.

It is an established rule of interpretation that Congress cannot be presumed to have done a futile thing, so there must be some meaning to the proviso clause and some areas of activity in which Federal Trade Commission jurisdiction is precluded because of it. The problem in this case is to determine whether the complaint raises issues which project beyond the precluded area.

This proceeding differs from some others now before the Commission in that the respondent here involved is licensed to do business only in its domiciliary state, and carries on all of its interstate business by mail from that state.

The State of Missouri has laws pertinent to this proceeding, two of which provide as follows:

(1) Chapter 376, Life and Accident Insurance, of the Revised Statutes of Missouri, 1949:

376.590 Misrepresentations, false estimates and circulars prohibited—agents—notes to be held until policy delivered.

1. No life insurance company doing business in this state, and no officers, director, or agent thereof, shall issue or circulate, or cause or permit to be issued or circulated, any estimate, illustration, circular or statement of any sort misrepresenting the terms of any policy issued by it or the benefits or advantages promised thereby, or the dividends or shares of surplus to be received thereon, or shall use any name or title of any policy or class of policies misrepresenting the true nature thereof.

2. Any person who shall solicit an application for insurance upon the life of another shall, in any controversy between the assured or his beneficiary and the company issuing any policy upon such application, be regarded as the agent of the company and not the agent of the assured, nor shall any life insurance company or agent sell, discount or otherwise dispose of any note or notes taken for payment of life insurance premium or premiums, before delivering to the applicant, in person, the policy for which said note or notes shall have been given.

376.600. Penalty for violating section 376.590.

Any life insurance company which may violate any of the provisions of section 376.590, or which may permit any of its agents or representatives in this state to violate said provisions, shall have its certificate of authority or license to transact business in Missouri revoked by the state superintendent of insurance, and shall be for a period of five years barred from the further

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transaction of business in this state; and any agent, solicitor or representative in this state of any such insurance company who shall violate any of the provisions of said section shall be deemed guilty of a misdemeanor, and, on conviction thereof, in any court of competent jurisdiction in this state, shall be fined not less than fifty nor more than five hundred dollars for each such offense or imprisoned in the county or city jail for not less than ten days nor more than six months, or by both such fine and imprisonment.

(2) Chapter 561, Crimes and Punishment:

561.660. Publication of untrue, misleading or deceptive advertisements—penalty.

1. Any person, firm, corporation, or association who, with intent to sell or in anywise dispose of merchandise, securities, service or anything offered by such person, firm, corporation or association, directly or indirectly, to the public for sale or distribution or with intent to increase the consumption thereof or to induce the public in any manner to enter into any obligation relating thereto or to acquire title thereto or an interest therein, makes, publishes, disseminates, circulates, or places before the public, or causes, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, *in this state*, in a newspaper or other publication or in the form of a book, notice, handbill, poster, bill, circular, pamphlet, or letter or in any other way, an advertisement of any sort regarding merchandise, securities, service or anything so offered to the public, which advertisement contains any assertion, representation or statement of fact which is untrue, deceptive or misleading, shall be guilty of a misdemeanor.

2. And shall upon conviction thereof be punished by a fine of not less than twenty-five dollars nor more than five hundred dollars, or by imprisonment in the county jail not less than ten days nor more than ninety days, or by both such fine and imprisonment; providing, that nothing herein shall apply to any proprietor or publisher of any newspaper or magazine who publishes, disseminates, or circulates any such advertisement without the knowledge of the unlawful or untruthful nature of such advertisement.

[Emphasis supplied, except for headings.]

The Missouri law also establishes a Division of Insurance headed by a Superintendent of Insurance, which has supervisory power over every insurance company organized and licensed in the state:

(a) to approve or disapprove, before use, every insurance policy offered for sale;

(b) to conduct, every three years or oftener, examination of the affairs of such companies;

(c) to investigate and take action with respect to complaints relating to payment of claims or to advertising representations;

(d) to require insurance companies to file with its powers of attorney authorizing it to accept, in their behalf, service of process in legal actions in every state in which such company's policy-holders reside.

Under these powers the Missouri Division of Insurance takes action on complaints which arise outside the state as well as on those which come from within.

Counsel for respondent contend that respondent's business is conducted entirely within the State of Missouri, including all of its activities in furtherance of its advertising program, and that under these laws and to the extent of all the practices charged in the complaint, the respondent is fully regulated by the State of Missouri to the exclusion of jurisdiction by the Federal Trade Commission.

Under Sections 376.590 and 376.600, the State of Missouri exercises full charter power over the respondent and, for violation of the provisions of law and regulations, can cancel or revoke respondent's charter. Such action would effectually terminate all of respondent's activities, including its advertising practices. Counsel for respondent argue that this power thus to terminate the practices of respondent which are complained of in this proceeding is regulation within the language of Public Law 15, sufficient to preclude Federal Trade Commission jurisdiction. But this argument fails to differentiate between charter power and police power. Public Law 15 does not curtail the one nor extend the other. No matter what may result from this proceeding, the charter power of the State of Missouri will not be curtailed, nor will its police power be extended.

The legislative history of Public Law 15 clearly shows that the phrase "regulated by state law" refers to taxing and policing, not to chartering. Consequently, the contention that Missouri can effectually control or regulate respondent's interstate activities through its power to revoke or suspend respondent's charter fails. The charter power of a state cannot be used as a substitute for its police power, and the instant proceeding is in all essentials a policing action. If respondent's contention were accepted that the charter power of Missouri is so effective, it would lead to the conclusion that the citizens of other states, in which respondent's advertising is circulated, are at the administrative mercy of those officials of the State of Missouri who exercise authority relating only to respondent's charter.

The provisions of Section 561.660 of the Missouri statute, quoted above, are directed to the making, publishing or circulation of misleading and deceptive advertising "in this state". The limitation "in this state" is specific and clear. If there had been any idea in the minds of Missouri's legislators that the police power of Missouri might extend beyond the state's boundaries, that idea is negated by the unequivocal language of the statute.

It follows, therefore, that there is an area of respondent's activities in which the Missouri statutes do not apply, and in that area the Federal Trade Commission may properly exercise jurisdiction.

Section 561.660 of the Missouri statute expressly limits the jurisdiction of Missouri to misleading and deceptive advertising practices carried on within the boundaries of that state; the Federal Trade Commission's authority is applicable to activities taking place across state lines in interstate commerce. The two therefore do not conflict, and the fact that Missouri still has complete jurisdiction over the respondent so far as charter power is concerned is completely irrelevant to the exercise by the Federal Trade Commission of its police power over false and deceptive acts and practices in interstate commerce.

Accordingly it is concluded that the Federal Trade Commission has jurisdiction over respondent so far as concerns the acts and practices herein complained of.

II. ISSUES OF FACT

1. Only two of respondent's policies were offered in evidence. One of these, a doctor's expense policy, may be disregarded because there are no charges of misrepresentation as to it, and there is no evidence as to its sale and distribution. The other, a hospitalization and surgical policy, is referred to as the Provider, or New Provider, policy. At least 2,000 of these policies were issued in 1953 and 1954 to non-residents of Missouri. Some of them were sold by radio, others by mail advertising.

2. Basically, the Provider policy provides indemnity for loss of life by accidental bodily injury, and for hospitalization and surgery due to sickness or accident; but through the use of various riders the policy contract can be modified or enlarged to cover a variety of contingencies, and the respondent refers to its combined available coverages as the American Plan. Some riders are applicable to and provide for maternity benefits, additional surgical benefits, and additional hospital-room benefits.

Respondent's Advertising and Business Practices

3. Respondent has used radio stations KMOX and WEW, of St. Louis, WBEM of Chicago, KOAM of Pittsburg, Kansas, and an unidentified station in Kansas City to interest the public in its Provider policy and to induce inquiries by mail for further information. The number of sales resulting from this advertising cannot be determined, but in every instance information in addition to that contained in the radio script was furnished to the prospect. Only one radio script is shown in the record, and there is no evidence as to the number or source of inquiries received as a result of its use.

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Respondent's radio advertising ceased in 1954. Respondent has used no newspaper or magazine advertising. The names of prospects have come in from the radio advertising or were procured through policy-holders.

4. Upon receipt of the name of a prospective purchaser of accident and health insurance, respondent company sent its first form-letter, which always was accompanied by a brochure describing the policy, two application forms, and a return envelope addressed to the company. Sometimes one or more stuffers describing benefits or containing favorable comments from policy-holders were enclosed. There were approximately a dozen varieties of such stuffers. Often a miniature (half-size) policy, and a form for recommending names and addresses of friends who might be interested in respondent's policies, were included. During the latter part of 1954, the mailing of the brochure was discontinued and a copy of the policy has since been substituted in its place and included in all mailings.

5. About the tenth day after the mailing of this first letter, if no favorable reply was had, the company sent out a second letter, with which was enclosed the brochure, two application forms and sometimes one or more of the stuffers (during the latter part of 1954 and thereafter the miniature policy was used instead of the brochure). Thereafter eight more form letters were mailed in sequence with similar enclosures. The first two of these were mailed at ten-day intervals, the last six at intervals of thirty days. How many of these letters were sent out and the areas into which they were mailed is not disclosed.

6. The number of policies that may have been purchased as a result of anyone of these mailings cannot be determined. It is reasonable to conclude that some policies were purchased following each mailing, but after the first mailing the inducing cause of a purchase may have been the cumulative effect of all the literature received, or it may have followed from a specific statement contained in any one of the pieces of literature received.

7. Each person who desired one of respondent's policies sent in his application and initial premium payment by mail. The statements contained in the application were relied upon by respondent, except for an occasional credit check, and no medical examination was required. Upon approval of an application, a policy was issued by respondent and mailed. If a policy lapsed, respondent sent the policy-holder a "conservation" letter, to which was attached a reinstatement application. If no favorable response was received within six months, a second lapse-letter with another reinstatement application was mailed. Claims were also handled by mail.

Representations

8. By the various advertising statements used, the complaint alleges four specific false, misleading and deceptive representations have been made by respondent with respect to its Provider policy. These will be discussed seriatim.

9. The first such allegation is that the respondent has falsely represented

That the indemnification provided by said policy against loss caused by hospitalization and surgical operations as a result of sickness or accident, can be continually renewed at the option of the insured, regardless of impairment of risk due to the incidence of sickness or accident, in some cases up to 65 years of age and others up to 75 or 90 years of age.

10. The following and similar statements appearing in respondent's advertising material constitute the basis for this charge of misrepresentation:

- (1) Benefits do not reduce because of age.
- (2) There is no reduction of benefits, ever.
- (3) Benefits are not reduced because of age.
- (4) * * * There is no reduction of benefits for minors or for older persons. The premiums are NOT increased because of age (except in the case of children when they attain age 18) nor is the policy ever cancelled because of age. Hospital rooms, board and general nursing care benefits are paid for one day and up to one year if you have to stay that long. * * *
- (5) The policy will NOT be cancelled EVER because of age.
- (6) * * * the features and liberal benefits are available to all from birth to 65 years of age who are in good health. * * *

11. Through use of the foregoing statements and others of similar import respondent directly or by implication has represented that its "New Provider" policy will continue to offer protection to an insured up to age 65 with full indemnification. To a prospective purchaser of such a policy this is an important feature. In fact, however, the policy specifically provides that the respondent at its option may refuse to accept any renewal premium for any reason whatsoever, thus, in effect cancelling its contract with the insured. Under the express terms of the policy an insured may be cancelled out on any premium anniversary date even though he may have paid premiums over a period of many years without having made any claim whatever upon respondent.

12. The second allegation of misrepresentation is that the respondent has advertised that the Provider policy "provides up to \$100.00 indemnity for surgical expense resulting from each or all of 64 different surgical operations", whereas, in fact, \$100.00 indemnifica-

tion is provided for only one operation, namely, cutting into the cranial cavity. The policy sets forth a schedule of 64 different operations and states maximum indemnity for each; for each of 60 the insured is offered indemnification of \$50.00 or less; for each of two others indemnification is \$60.00; for one other \$75.00; and for the cranial operation, \$100.00. The policy also contains a limitation that not more than one, the greater, of the amounts specified in the schedule will be paid on account of any one sickness or for injury resulting from any one accident.

13. Among the advertising statements on which the foregoing allegation is predicated are the following:

The radio script contains the statement:

* * * sickness requiring surgery covered after policy has been in force six months * * * Benefits for 64 specific surgical operations.

The brochure states:

YOU GET \$5.00 TO \$100.00

For surgical operations you get from \$5.00 to \$100.00 to help you pay your surgeon while hospitalized. There are 64 operations listed in the Schedule of Operations.

In the first form letter appears the following:

In addition, the policy will pay you benefits for 64 surgical operations, as well as benefits for ambulance, blood transfusions, oxygen tent, and rental of wheel chair or crutches. * * *

14. In two cases similar language, used in somewhat different context, has been interpreted. Each of the two examiners who heard these cases separately found that the language complained of was not deceptive, but upon appeal the Commission, in both cases, held to the contrary, concluding that the language is misleading and deceptive.

15. In the *American Hospital and Life Insurance Company* case, Docket 6237, decided April 24, 1956, the language to be interpreted was as follows:

SURGERY

from \$3.00 to \$150.00

\$ 1 5 0 . 0 0

*depending on seriousness
of operation*

[Emphasis added.]

The Commission said:

Appraising this advertisement as it is likely to be read by unsuspecting, incautious members of the purchasing public, we gain the impression that the policy will indemnify up to a maximum sum of \$150 for any surgical operation serious enough to cost such an amount.

16. In the *National Casualty Company* case, Docket 6311, decided May 21, 1956, the Commission quoted from the *American Hospital* decision, and added:

Our conclusion is no different here. As the courts have uniformly recognized, it is not the trained and experienced experts who need protection, but the members of the buying public who, in making purchases, are governed largely by appearances and general impressions. Furthermore, the ultimate impression upon the mind of a reader arises from the sum total of not only what is said in an advertisement but also of all that is reasonably implied. *Charles of the Ritz Dist. Corp. v. Federal Trade Commission*, 143 F. 2d 676 (C.A. 2, 1944). And it seems obvious to us that the statements referred to, *especially when read in conjunction with such superlatives as* "The Most Complete Coverage," "Complete Protection", "All Inclusive Hospital—Surgical—Nurse Protection," and "Maximum Protection at Moderate Cost," which have also appeared in the respondent's advertisements, are almost certain to mislead readers into thinking they are getting protection which the policies do not provide. The respondent's practice of describing in its advertising the maximum benefits that may be received under the policies without disclosing the schedule of payments for which the policies actually provide is thus unfair and deceptive within the meaning of the Federal Trade Commission Act. [Emphasis added.]

17. Respondent points out that its advertising differs from the advertising interpreted by the Commission in these two cases, but in the last sentence quoted above from the *National* case the Commission indicates its belief that insurance advertising should disclose "the schedule of payments for which the policies actually provide". This the respondent in the instant case did not do, except when a sample policy was enclosed with the literature mailed to a prospective purchaser. This failure on the part of the respondent brings its advertising within the scope of the Commission's ruling in the *National* case, and, upon the basis of the Commission's decision in that case, it is concluded that respondent's advertising is, in this respect, deceptive and misleading.

18. The third allegation of misrepresentation is that respondent has represented that the lump sum benefit for loss of life due to travel accident in a common carrier by land, water or air is without other qualification or limitation. This is charged to be deceptive and misleading, since it differs from the policy provision, which is as follows:

If death of the insured shall result solely from accidental bodily injury within 90 days after such injury, while riding as a fare-paying passenger in any public conveyance including a licensed passenger airplane provided by an incorporated common carrier of passengers and while operated by a licensed transport pilot upon a regularly scheduled passenger route between definitely established airports, the Company will pay in lieu of all other indemnity, Travel Accidental Death Benefit of Twenty-Five Hundred Dollars (\$2500.00).

19. Among respondent's advertising statements are the following:

Benefits for loss of life by travel accident.

The New Provider Hospitalization Policy pays your beneficiary, in lieu of other benefits, \$2,500 for death as a result of accident while travelling on a public conveyance (or common carrier) by land, water or air.

You are covered for death as a result of an accident while travelling as a fare-paying passenger in a common carrier by land, water, or air.

There is also a lump sum benefit \$2,500.00 for loss of life due to travel accident by land, water or air.

Pays \$2,500.00 lump sum benefit for travel accidental death, at no extra cost.

20. The foregoing advertising statements are not false, but they do not disclose fully the terms and conditions applicable to the payment of indemnification for accidental death.

21. Respondent contends (a) that there can be no deception by the failure to set forth in the advertising the provision that death must result within ninety days after injury, since this provision is never enforced by the company and may not be interjected as a basis for rejecting any claim under the rules of the Missouri Department of Insurance; (b) that it is specifically stated in the brochure, and by clear inference disclosed in its other advertising literature, that a claimant policy-holder must have been a fair-paying passenger on a common carrier; and (c) that under the ruling in *Alberty v. F.T.C.*, 182 F. 2d 36, the Federal Trade Commission may not require a respondent to disclose information not required to prevent falsity, and therefore that respondent's failure to state in its advertising the limitation that if death results from an air-travel accident it must have happened in a "licensed passenger airplane provided by an incorporated common carrier of passengers and while operated by a licensed transport pilot upon a regularly scheduled passenger route between definitely established airports", and that the accidental injury must be the sole cause of the death, is not such a failure as to support action by the Federal Trade Commission.

22. Even if contentions (a) and (b) be accepted, under the Commission's recent rulings and decisions, contention (c) must be rejected, and the conclusion reached that respondent's failure to disclose fully in its advertising matter the terms and conditions upon which indemnification will be made in case of accidental death constitutes unfair and deceptive advertising within the meaning of the Federal Trade Commission Act.

23. Among the advertising statements upon which the fourth set of charges of the complaint is based are the following:

As an example, Friends, unlike other Hospitalization plans, this policy pays benefits for hospital room and board for one day, one week, one month or a

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whole year. Government hospitals, which are usually free are excepted. No waiting 30 or 60 days, it covers you immediately for all accidents and all sickness not requiring surgery . . . sickness requiring surgery covered after policy has been in force six months * * * Benefits for 64 specific surgical operations * * * Benefits for loss of life for travel accident * * * for those who want it a Maternity Rider is available at a small additional charge * * * EXTRA BENEFITS SUCH AS CASH FOR BLOOD TRANSFUSIONS * * * RENTAL OF WHEEL CHAIR OR CRUTCHES * * * OXYGEN, AND AMBULANCE FEES * * * NO DEDUCTION OF BENEFITS ON ACCOUNT OF AGE (Radio script).

* * * ALSO PAYS benefits for hospitalization due to sickness, accident or surgery. Full benefits paid to children. To our knowledge, the NEW PROVIDER POLICY is the most liberal yet the lowest priced hospitalization plan now available. Read inside for all the tremendous advantages and cash benefits offered * * * all for only 3¢ a day! * * * (Brochure).

* * * NOTE: For those who want it, a Maternity rider is available at small additional charge. Confinement in Government hospitals, or any Institution that is not equipped with a laboratory, operating room, and Registered Nurse, always on duty, are not covered. Sickness resulting in surgery is covered if the cause originates after policy has been in force six months * * * (Brochure).

YOU GET \$5.00 TO \$1,825.00

If sickness strikes and you enter any hospital, you will receive actual expenses and not to exceed \$5.00 per day for hospital room, board and general nursing care. These benefits are paid for one day, one week, one month, or a whole year (Brochure).

YOU GET \$5.00 TO \$1,825.00

If accident strikes and you enter any hospital, benefits begin at once. You will receive actual expenses not to exceed \$5.00 per day for hospital room, board and general nursing care. These benefits are paid for one day, one week, one month, or a whole year (Brochure).

* * * The policy goes into effect immediately, from the first day of hospital confinement for either sickness or accident, except in the case of sickness requiring a surgical operation, then the usual six months waiting period applies (First form letter).

Send in your application right now, while it is still fresh in your mind. The self-addressed envelope needs no postage and you will get your PROVIDER policy within a few days by mail. It will be in full force when the mailman delivers it to you (Ninth form letter).

I represent to my best knowledge that all persons named are in good health and that there is no existing condition which may require either Hospitalization or Surgical operation, except as follows: -----

(Application form, second paragraph)

24. Through these and other similar statements, it is alleged that the respondent has falsely and deceptively represented "that the said policy provides indemnification for loss caused by hospitalization or surgical expense resulting from any or all sicknesses or accidents except

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a. Those existing conditions which, in the opinion of the insured, might require either hospitalization or operation and which were set forth in good faith by the insured in his application for said policy, or for any renewal thereof, and which were subsequently excepted specifically from coverage by indorsement on the policy;

b. Childbirth, unless covered by special rider;

c. Sickness requiring a surgical operation prior to the expiration of six months from the effective date of the policy;

d. Those incurred during service in the armed forces, or treated in Government hospitals, or provided for under Workmen's Compensation Laws;

25. It is charged that such representations are false, misleading and deceptive, because, in truth and in fact, respondent's policy expressly provides that "there shall be no indemnification for loss caused by hospitalization or surgical expense resulting from:

a. Any condition which was in existence prior to the effective date of the policy;

b. Childbirth;

c. Any sickness requiring a surgical operation unless such sickness had its origin after the expiration of six months from the effective date of the policy;

d. Those incurred during service in the armed forces, or treated in government hospitals, or provided for under Workmen's Compensation Laws; (and)

e. Said policy further expressly provided, among other exclusions and limitations, for no indemnification for expenses due to pregnancy or complications of pregnancy, treatment of mental diseases or derangement or nervous illnesses, war or acts of war, suicide or attempts thereat while sane, and losses resulting from the insured being intoxicated or under the influence of alcoholics or narcotics unless administered on the advice of a physician.

The general charge is that the respondent has falsely and deceptively represented that, except for specific limitations hereinafter discussed, its policy provides indemnification for losses or expenses resulting from any or all sicknesses and accidents.

26. Respondent's policy does not so provide. Specifically excluded from coverage under respondent's policy are mental disease or derangement or nervous ailments, any loss caused by war or any act of war, suicide or attempt thereat while sane, disease contracted or injury incurred while the insured is engaged in the commission of a felony or in an illegal occupation, or resulting from the insured being intoxicated or having used narcotics without advice of a physician. Since these limitations and conditions are not disclosed in respondent's advertising used during the period herein involved, this lack of disclosure, under the decisions of the Commission, constitutes unfair and deceptive acts and practices.

27. In addition to the general charge, there are some specific charges alleged. One of these is to the effect that respondent represented by implication that its "New Provider" policy indemnifies for

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loss of time due to conditions existing prior to the effective date of the policy which are not listed on insured's application for a policy. In truth and in fact respondent's "New Provider" policy expressly excepts from its coverage any indemnity for * * * any condition which was in existence prior to the effective date of this policy or at the time of any reinstatement * * *. Thus, respondent indicates its coverage is all inclusive with certain exceptions; but when compared with the policy these statements are misleading and deceptive.

III. CONCLUSIONS

Upon the basis of the entire record the following conclusions are reached:

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

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

It is ordered, That the respondent, American Life and 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, 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 condi-

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

3. That said policy provides for indemnification against losses due to sickness or accident, unless a statement of all the conditions, exceptions, restrictions and limitations affecting the indemnification actually provided are set forth conspicuously, prominently, and in sufficiently close conjunction with said representations as will fully relieve it of all capacity to deceive.

4. That said policy provides for a stipulated sum to be paid upon the accidental death of the insured unless full disclosure of the conditions, exceptions, restrictions and limitations affecting the indemnification actually provided is set forth conspicuously, prominently, and in sufficiently close conjunction with the representation as will fully relieve it of all capacity to deceive.

OPINION OF THE COMMISSION

By SECRET, Commissioner:

Respondent American Life and Accident Insurance Company is engaged in the sale of accident and health insurance and is licensed to do business only by the State of Missouri. It conducts its business in all other states by mail. The complaint herein charged respondent with false and misleading and deceptive practices in the solicitation and sale of one of its accident and health policies in violation of Section 5 of the Federal Trade Commission Act. As indicated, only respondent's "Provider" or "New Provider" policy is involved here. The complaint charged four specific misrepresentations as to the "New Provider" policy covering:

- (1) its renewability or duration;
- (2) the maximum amounts provided for surgical operations under a surgical schedule;
- (3) certain limitations upon travel death benefit provisions; and

(4) the general classes of sickness and accidents covered.

The hearing examiner's initial decision dismissed the charge in the complaint relating to renewability or duration. He found that representations as to maximum amounts payable for surgical operations were false and misleading. As to representations with regard to travel death benefit provisions, the initial decision found respondent's representations in this regard to constitute unfair and deceptive advertising. With respect to the charge of misleading advertising of indemnification for all sickness and accidents, the hearing examiner found these generally to have been substantiated but failed to declare as false and misleading specific representations attacked in the complaint regarding indemnification for conditions existing prior to the effective date of the policy, coverage for childbirth, indemnification for surgery required prior to expiration of six months from the effective date of the policy, and coverage for sickness or accident "incurred during service in the armed forces, or treated in Government hospitals, or provided for under Workmen's Compensation Laws."

Finally, the hearing examiner made the requisite findings as to the existence of public interest and jurisdiction and concluded that respondent's advertising representations were unfair, misleading and deceptive in the respects indicated. He ordered the complaint dismissed, however, on the ground:

that since the acts and practices complained of in this proceeding have been discontinued and no reasonable likelihood exists that they will be resumed by respondent, all that could be accomplished herein by the issuance of a cease and desist order has already been accomplished * * *.

Counsel supporting the complaint have appealed from the initial decision and the matter is now before us for final decision on the merits on the basis of the whole record, briefs on appeal and in opposition thereto and on oral argument before the Commission.

Counsel supporting the complaint contend that respondent has failed to provide any reasonable basis for dismissal of the complaint on the ground of discontinuance of practices charged. In support of the conclusion that respondent has abandoned the practices complained of, the hearing examiner refers to respondent's prior course of dealings with the Commission in connection with respondent's activities relative to certain trade practice conference rules for mail order and health and accident insurance. It is our opinion that while respondent's prior course of dealing with the Commission might have some bearing on respondent's good faith, the record as a whole does not support the contention that the respondent has in fact discontinued use of the practices alleged to be unlawful.

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The facts are that respondent discontinued radio advertising in 1954, prior to commencement of this proceeding, and the hearing examiner correctly so found. Also, the record shows that use of a brochure which accompanied respondent's mailings to prospective customers likewise was discontinued at the same time. The radio script and brochure contained most of the representations alleged to be deceptive. However, there is no evidence that respondent has discontinued the use of ten form letters mailed in series to each prospective customer unless and until an application for a policy is forthcoming. (Since the latter part of 1954, a sample copy of the "New Provider" policy has accompanied all such letters in all mailings.) And, from our examination of these form letters, received in the record as exhibits, we conclude that respondent is continuing the use of most, if not all, of the deceptive representations, or statements substantially similar to them—all as more particularly set forth in the Commission's findings of fact herein. We also are of the opinion that the fact that a sample copy of respondent's "New Provider" policy currently accompanies each of the series of ten form letters does not cure the patently deceptive nature of the misrepresentations contained in those form letters. In *American Hospital and Life Insurance Company, supra*, in similar circumstances, the Commission held as follows:

Rather it is our view that the brochure functions as a self-contained piece of advertising that of itself is likely to induce a prospect to purchase respondent's insurance.

Furthermore, we do not believe that the prospective purchaser is under any obligation to investigate the extent to which respondent's unrestricted representations of coverage for illness or accidents are untrue. "Under repeated decisions, the purchaser is entitled to rely upon the representations made. He need not distrust what is told him. * * * It goes without saying almost that it is extremely difficult for a layman to understand the terms and conditions of such policies as these, but whether the applicants did or did not read and understand the policies is beside the point." *United States v. Sylvanus*, 192 F. 2d 96, 105 (7th Cir. 1951), cert. denied, 342 U.S. 943 (1952).

If the busy or careless businessman is entitled to protection from deceptive printed forms, even though an attentive, careful person would not be deceived thereby, *Independent Directory Corp. v. F.T.C.*, 188 F. 2d 468, 470, 471 (2d Cir. 1951), it does not devolve upon respondent's prospects to ascertain the extent to which respondent's advertising may or may not exaggerate or falsify. The Federal Trade Commission Act is violated if the first contact or interview is secured by deception even though the true facts are made known to the purchaser before he enters into the contract of purchase. *Carter Products, Inc. v. F.T.C.*, 186 F. 2d 821, 824 (7th Cir. 1951).

Another questionable premise in the examiner's reasoning is that "any reasonably intelligent person considering the purchase of health and accident insurance would be expected to know that health and accident policies do

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not ordinarily cover all illnesses and all accidents, regardless of their nature or time of origin or occurrence." Apart from the fact that the Federal Trade Commission has the duty to protect not only the "reasonably intelligent" but also the ignorant, the unthinking, the credulous, and the inexperienced, *Charles of the Ritz Dist. Corp. v. F.T.C.*, 143 F. 2d 676, 679 (2d Cir. 1944), we question whether the fact asserted by the examiner to be common knowledge—if it be a fact—is generally known even to the "reasonably intelligent." It is certainly not beyond the realm of actuarial conceivability, not to say possibility, that in these United States in the mid-twentieth century insurance could be written which would afford protection against all illness and all accidents.

These principles are controlling here and the hearing examiner clearly erred in holding that respondent has discontinued the practices questioned in the complaint in this proceeding with reasonable assurance that they will not be resumed. The facts of record are to the contrary. The initial decision will be modified accordingly.

Having thus ruled on the matter of discontinuance, the Commission has before it only two other questions for consideration. Are respondent's representations as to the renewability and duration of its "New Provider" policy deceptive and misleading? Has respondent misrepresented the general classes of sickness and accidents against which the policy indemnified, including illness originating before issuance of the policy?

The hearing examiner's initial decision found that respondent's representations as to amounts payable for surgical operations (Initial Decision, Paragraphs 14 through 19, both inclusive) and as to travel death benefit provisions (Initial Decision, Paragraphs 20 through 24, both inclusive) constitute misleading and deceptive advertising. With these findings we are in agreement and we do not propose to disturb them.

On the matter of renewability or duration of respondent's policy, the hearing examiner dismissed the charges of the complaint on the authority of *American Hospital and Life Insurance Company, supra*. In this connection, counsel supporting the complaint point out that the particular charge in the *American Hospital* case was dismissed by the Commission because the advertising stated "NO AGE PROVISION terminating or reducing benefits because of increasing age." The Commission held such statement literally to be true inasmuch as respondent's policies did not contain a provision reducing benefits because of age.

Here, respondent, in its form letters, states as follows:

Benefits do not reduce because of age. (Comm. Exs. 3, 10, 18.)

There is no reduction in benefits, ever. (Comm. Ex. 8.)

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There is no reduction of benefits for minors or older persons * * * nor is the policy ever cancelled because of age * * * persons up to age of ninety are eligible. (Comm. Ex. 22.)

The policy will not be cancelled, ever, because of age. (Resp. Ex. 8.)

We conclude that such statements give the impression that respondent's "New Provider" policy will continue in effect with full indemnification so long as the insured pays premiums and that such representations constitute false and misleading representations that respondent's policies may be kept in force continuously at the option of the insured when, in fact, the policies are terminable at any premium date at the option of respondent. *National Casualty Company*, Docket No. 6311, decided May 21, 1956.

The fourth specific misrepresentation charged in the complaint is that respondent has falsely and deceptively represented that its "New Provider" policy, with certain specific exemptions, indemnifies against losses or expenses resulting from *any or all* sicknesses and accidents. On the facts as disclosed by the record, the hearing examiner found that respondent misrepresented the scope of sickness and accident coverage provided by its policy because of inadequate disclosure in advertising of the exceptions to such coverage as provided in the policy.

The examiner further found, however, that respondent's advertising is not susceptible of the interpretation that it represents that its policy covers all sickness or accidents arising out of conditions which existed prior to the effective date of the policy, and, this finding is assigned as error by counsel supporting the complaint.

The initial decision (Paragraphs 30, 31 and 32) interprets the complaint as alleging that respondent's advertising is deceptive because it represents, contrary to the fact, that its policy does not cover childbirth and certain other conditions. The Commission does not construe the complaint as so charging and is of the opinion that the pertinent portions of the complaint involved¹ merely recite conditions represented in respondent's advertising as being expressly excluded from indemnification under the policy for the purpose of emphasizing conditions that were not clearly shown in respondent's advertising as not being covered by its "New Provider" policy. It follows, therefore, that there is no basis for the findings contained in the aforesaid paragraphs of the initial decision.

As to the appeal of counsel supporting the complaint, we agree that respondent's advertising inescapably implies that coverage of its policy is comprehensive but for the exceptions stated in said adver-

¹ Complaint Paragraph Six (4), and Paragraph Seven (4).

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tising. It is clear that respondent's "New Provider" policy by its express terms specifically provides that it does not indemnify for "any condition which was in existence prior to the effective date of this policy." Respondent's representations in this regard are incomplete and at variance with the policy provisions and, therefore, are deceptive and misleading.

The appeal of counsel supporting the complaint should be granted. An order modifying the initial decision in accordance with the foregoing considerations and including an order to cease and desist in conformity with this opinion will be entered in lieu of the order of dismissal by the hearing examiner.

CONCURRING OPINION OF CHAIRMAN GWYNNE AND COMMISSIONER TAIT

It is our view that the Commission has jurisdiction herein for the reasons outlined in the concurring opinion in Travelers Health Association, Docket 6252, and the dissenting opinion in North American Accident Insurance Company, Docket 6456. It also should be noted that the respondent here admits the jurisdiction of this Commission.

The order should be limited accordingly.

FINAL ORDER

Counsel supporting the complaint having timely filed an appeal from the initial decision of the hearing examiner in this proceeding; and the matter having been heard by the Commission on briefs and oral argument; and the Commission having rendered its decision granting the appeal of counsel supporting the complaint and directing modification of the initial decision in conformity with the Commission's opinion:

It is ordered, That the following paragraphs numbered 10 and 11 be, and they hereby are, substituted for Paragraphs 10 through 13, inclusive of the findings of fact contained in the initial decision:

"10. The following and similar statements appearing in respondent's advertising material constitute the basis for this charge of misrepresentation:

- (1) 'Benefits do not reduce because of age.'
- (2) 'There is no reduction of benefits, ever.'
- (3) 'Benefits are not reduced because of age.'
- (4) ' * * * There is no reduction of benefits for minors or for older persons. The premiums are NOT increased because of age (except in the case of children when they attain age 18) nor is the policy ever cancelled because of age. Hospital rooms, board and general nursing care benefits are paid for one day and up to one year if you have to stay that long. * * * '

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(5) 'The policy will NOT be cancelled EVER because of age.'

(6) ' * * * the features and liberal benefits are available to all from birth to 65 years of age who are in good health. * * * .'

"11. Through use of the foregoing statements and others of similar import respondent directly or by implication has represented that its 'New Provider' policy will continue to offer protection to an insured up to age 65 with full indemnification. To a prospective purchaser of such a policy this is an important feature. In fact, however, the policy specifically provides that the respondent at its option may refuse to accept any renewal premium for any reason whatsoever, thus, in effect cancelling its contract with the insured. Under the express terms of the policy an insured may be cancelled out on any premium anniversary date even though he may have paid premiums over a period of many years without having made any claim whatever upon respondent."

It is further ordered, That the following paragraph be, and it hereby is, substituted for Paragraph 29 of the initial decision:

"27. In addition to the general charge, there are some specific charges alleged. One of these is to the effect that respondent represented by implication that its 'New Provider' policy indemnifies for loss of time due to conditions existing prior to the effective date of the policy which are not listed on insured's application for a policy. In truth and in fact respondent's 'New Provider' policy expressly excepts from its coverage any indemnity for * * * any condition which was in existence prior to the effective date of this policy or at the time of any reinstatement * * *. Thus, respondent indicates its coverage is all inclusive with certain exceptions; but when compared with the policy these statements are misleading and deceptive."

It is further ordered, That Paragraphs 14 through 28, both inclusive, of the initial decision be renumbered 12 through 26, both inclusive.

It is further ordered, That Paragraphs 30 through 36, both inclusive, be deleted from the initial decision.

It is further ordered, That the following paragraphs be, and the same hereby are, substituted for that portion of the initial decision designated "III. Conclusions":

"III. CONCLUSIONS

"Upon the basis of the entire record the following conclusions are reached:

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

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

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

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

"3. That said policy provides for indemnification against losses due to sickness or accident, unless a statement of all the conditions,

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exceptions, restrictions and limitations affecting the indemnification actually provided are set forth conspicuously, prominently, and in sufficiently close conjunction with said representations as will fully relieve it of all capacity to deceive.

"4. That said policy provides for a stipulated sum to be paid upon the accidental death of the insured unless full disclosure of the conditions, exceptions, restrictions and limitations affecting the indemnification actually provided is set forth conspicuously, prominently, and in sufficiently close conjunction with the representation as will fully relieve it of all capacity to deceive."

It is further ordered, That respondent, American Life and 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.

IN THE MATTER OF
PITTSBURGH PLATE GLASS COMPANY

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

Docket 6699. Complaint, Dec. 26, 1956—Decision, Apr. 19, 1957

Consent order requiring one of the leading manufacturers of automotive safety glass windshields and rear windows, to cease discriminating in price between competing purchasers by such practices as charging the Ford Motor Co. from 32% to 48% less for automotive safety glass than it charged glass distributors, and from about 59% to 67% less than it charged glass dealers.

Mr. William H. Smith for the Commission.

Cahill, Gordon, Reindel & Ohl, of New York, N.Y., and *Mr. Cyrus V. Anderson*, of Pittsburgh, Pa., for respondent.

INITIAL DECISION BY FRANK HIER, HEARING EXAMINER

Pursuant to the provisions of subsection (a) of section 2 of the Clayton Act (15 U.S.C. 13) as amended by the Robinson-Patman Act, the Federal Trade Commission on December 26, 1956, issued and subsequently served its complaint in this proceeding against respondent Pittsburgh Plate Glass Company, a corporation existing and doing business under and by virtue of the laws of the Commonwealth of Pennsylvania, with its office and principal place of business located at 1 Gateway Center, Pittsburgh, Pennsylvania.

On March 5, 1957, there was submitted to the undersigned hearing examiner an agreement between respondent and counsel supporting the complaint providing for the entry of a consent order. By the terms of said agreement, respondent admits all the jurisdictional facts alleged in the complaint and agrees that the record may be taken as if findings of jurisdictional facts had been duly made in accordance with such allegations. By such agreement, respondent waives any further procedural steps before the hearing examiner and the Commission; waives the making of findings of fact and conclusions of law; and waives all of the rights it may have to challenge or contest the validity of the order to cease and desist entered in accordance with this agreement. Such agreement further provides that it disposes of all of this proceeding as to all parties; that the record on which this initial decision and the decision of the Commission shall be based shall consist solely of the complaint and