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LEGAL NOTES

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FEDERAL ESTATE TAX—PREMIUM PAYMENT TEST: *United States v. Manufacturers National Bank* (United States Supreme Court, June 13, 1960) 363 U.S. 194. The insured died just prior to the date the premium payment test was abolished by the 1954 Internal Revenue Code. The Government claimed that his taxable estate should be increased by a portion of the policy proceeds by reason of the fact that he paid premiums on the policies on his life after the effective date of the premium payment test and prior to its repeal. Concededly he retained no incidents of ownership in these policies after 1936, which was prior to the date the premium payment test became effective.

The executor claimed that, so construed, the tax was a direct tax and not a tax on a transfer at death, and that since the tax was not apportioned the levy was unconstitutional. The executor also claimed that the Due Process Clause of the Fifth Amendment was violated because the tax was retroactive and was discriminatory.

The District Court agreed with the executor and held that the tax was unconstitutional. The Government took this direct appeal to the United States Supreme Court, which reversed the decision of the District Court and held that the tax was valid. The Court in its opinion stated:

> Under the statute, the occasion for the tax is the maturing of the beneficiaries' right to the proceeds upon the death of the insured. Of course, if the insured possessed no policy rights, there is no transfer of any interest *from him* at the moment of death. But that fact is not material, for the taxable "transfer," the maturing of the beneficiaries' right to the proceeds, is the crucial last step in what Congress can reasonably treat as a testamentary disposition by the insured in favor of the beneficiaries. That disposition, which began with the payment of premiums by the insured, is completed by his death. His death creates a genuine enlargement of the beneficiaries' rights. It is the "generating source" of the full value of the proceeds. See *Schwarz v. United States*, 170 F. Supp. 2, 6. The maturing of the right to proceeds is therefore an appropriate occasion for taxing the transaction to the estate of the insured. Cf. *Tyler v. United States*, 281 U.S. 497, 503, 504.
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> There is no inconsistency between such a view of the taxable event and the basic definition of the subject of the tax in Section 810. "Obviously, the word 'transfer' in the statute, or the privilege which may constitutionally be taxed, cannot be taken in such a restricted sense as to refer only to the passing of particular items of property directly from the decedent to the transferee. It must . . . at least include the transfer of property procured through expenditures by the decedent with the purpose, effected

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at his death, of having it pass to another." *Chase National Bank v. United States*, 278 U.S. 327, 337.

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It is said that the statute operates retroactively. But the taxable event—the maturing of the policies at death—occurred long after the enactment of Section 811(g)(2)(A) in 1942. Moreover, the payment of all but a few of the premiums in question occurred after the effective date of the statute, and those few were paid during the period after January 10, 1941, when regulations gave the insured fair notice of the likely tax consequences. See T.D. 5032, 1941-1 Cum. Bull. 427. Therefore, the statute cannot be said to be retroactive in its impact. It is not material that the policies were purchased and the policy rights were assigned before the statute was enacted. The tax is not laid on the creation or transfer of the policy rights, and it "does not operate retroactively merely because some of the facts or conditions upon which its application depends came into being prior to the enactment of the tax." *United States v. Jacobs*, supra, at 367.

The taxpayer argues, however, that the enactment of the statute subjected the insured to a choice between unpleasant alternatives: "[H]e could stop paying the premiums—in which case the policies would be destroyed; or, he could continue paying premiums—in which case they would be included in his estate." But when he gave away the policy rights, the possibility that he would eventually be faced with that choice was an obvious risk, in view of the administrative history of the "payment of premiums" test. See 1 Paul, Federal Estate and Gift Taxation, § 10.13. The executor should not complain because his decedent gambled and lost. And, while it may be true that the insured could have avoided the tax only at the price of a loss on an investment already made, that fact alone does not prove that the lawmakers did "a wholly arbitrary thing," or that they "found equivalence where there was none," or that they "laid a burden unrelated to privilege or benefit." *Burnet v. Wells*, 289 U.S. 670, 679. Without such a showing, it cannot be held that the tax offends due process.

This case removes any doubt as to the constitutionality of the premium payment test under the Federal Estate Tax Law. The Congress may in the future enact legislation to reimpose this test, as has been proposed from time to time.

SOCIAL SECURITY—NATURE OF THE BENEFIT: *Flemming v. Nestor* (United States Supreme Court, June 20, 1960) 363 U.S. 603. Nestor came to this country from Bulgaria in 1913. He was in covered employment under Social Security from 1936 to 1955, when he became eligible for benefits. He contributed as required during this period of coverage. These benefits were terminated in 1956 in accordance with a 1954 law, after Nestor was deported for having been a member of the Communist party from 1933 to 1939.

Nestor brought this action against Flemming, Secretary of Health, Education, and Welfare, claiming that the 1954 law was unconstitutional under the Due Process Clause of the Fifth Amendment to the Federal Constitution in that it deprived him of accrued property rights and otherwise violated his constitutional rights. The District Court agreed with Nestor that the statute was unconstitutional and Flemming appealed directly to the United States Supreme Court from this decision.

The Supreme Court reversed the judgment of the Court below, stating that Nestor had not been deprived of an "accrued property right" in that "Social

Security benefits cannot properly be considered to have been of that order."

The Court in its opinion went into detail in a discussion of the nature of Social Security, saying:

The Social Security system may be accurately described as a form of social insurance, enacted pursuant to Congress' power to "spend money in aid of the 'general welfare,' " *Helvering v. Davis, supra*, at 640, whereby persons gainfully employed, and those who employ them, are taxed to permit the payment of benefits to the retired and disabled, and their dependents. Plainly the expectation is that many members of the present productive work force will in turn become beneficiaries rather than supporters of the program. But each worker's benefits, though flowing from the contributions he made to the national economy while actively employed, are not dependent on the degree to which he was called upon to support the system by taxation. It is apparent that the noncontractual interest of an employee covered by the Act cannot be soundly analogized to that of the holder of an annuity, whose right to benefits is bottomed on his contractual premium payments.

It is hardly profitable to engage in conceptualizations regarding "earned rights" and "gratuities." Cf. *Lynch v. United States*, 292 U.S. 571, 576–577. The "right" to Social Security benefits is in one sense "earned," for the entire scheme rests on the legislative judgment that those who in their productive years were functioning members of the economy may justly call upon that economy, in their later years, for protection from "the rigors of the poor house as well as from the haunting fear that such a lot awaits them when journey's end is near." *Helvering v. Davis, supra*, at 641. But the practical effectuation of that judgment has of necessity called forth a highly complex and interrelated statutory structure. Integrated treatment of the manifold specific problems presented by the Social Security program demands more than a generalization. That program was designed to function into the indefinite future, and its specific provisions rest on predictions as to expected economic conditions which must inevitably prove less than wholly accurate, and on judgments and preferences as to the proper allocation of the Nation's resources which evolving economic and social conditions will of necessity in some degree modify.

To engraft upon the Social Security system a concept of "accrued property rights" would deprive it of the flexibility and boldness in adjustment to ever-changing conditions which it demands. See Wollenberg, Vested Rights in Social-Security Benefits 37 Ore. L. Rev. 299, 359. It was doubtless out of an awareness of the need for such flexibility that Congress included in the original Act, and has since retained, a clause expressly reserving to it "[t]he right to alter, amend, or repeal any provision" of the Act. § 1104, 49 Stat. 648, 42 U.S.C. § 1304. That provision makes express what is implicit in the institutional needs of the program. See Analysis of the Social Security System, Hearings before a Subcommittee of the Committee on Ways and Means, House of Representatives, 83d Cong., 1st Sess., pp. 920–921. It was pursuant to that provision that § 202 (n) was enacted.

We must conclude that a person covered by the Act has not such a right in benefit payments as would make every defeasance of "accrued" interests violative of the Due Process Clause of the Fifth Amendment.

The Court also denied Nestor's claim that the termination of benefits amounted to punishing him without a judicial trial, that it amounted to "a bill of attainder," or that it was an *ex post facto* law, all in violation of these sections of the Federal Constitution.

There was a vigorous dissent by Mr. Justice Black, in which Mr. Justice Douglas and Mr. Justice Brennan joined. There was another such dissent by Mr. Justice Brennan, with which the Chief Justice and Mr. Justice Douglas joined. In general, the dissenters took the position that several constitutional provisions were violated and they likened the Social Security benefit to an insurance benefit where the member had paid his premium. Mr. Justice Black in his dissenting opinion stated:

> The Court consoles those whose insurance is taken away today, and others who may suffer the same fate in the future, by saying that a decision requiring the Social Security system to keep faith "would deprive it of the flexibility and boldness in adjustment to ever-changing conditions which it demands." People who pay premiums for insurance usually think they are paying for insurance, not for "flexibility and boldness." I cannot believe that any private insurance company in America would be permitted to repudiate its matured contracts with its policyholders who have regularly paid all their premiums in reliance upon the good faith of the company. It is true, as the Court says, that the original Act contained a clause, still in force, that expressly reserves to Congress "[t]he right to alter, amend, or repeal any provision" of the Act. § 1104, 49 Stat. 648, 42 U.S.C. § 1304. Congress, of course, properly retained that power. It could repeal the Act so as to cease to operate its old-age insurance activities for the future. This means that it could stop covering new people, and even stop increasing its obligations to its old contributors. But that is quite different from disappointing the just expectations of the contributors to the fund which the Government has compelled them and their employers to pay its Treasury. There is nothing "conceptualistic" about saying, as this Court did in *Lynch*, that such a taking as this the Constitution forbids.

This decision is an important one, especially if the day ever comes when there is a general cutback by the Congress in Social Security benefits.

FEDERAL INCOME TAX—COMMISSION ON OWN POLICY: *Commissioner of Internal Revenue v. Minzer* (C. A. 5, June 3, 1960) 279 F.2d 338. The taxpayer was an insurance agent or broker who in 1954 procured or kept in force policies of insurance upon his own life. He received the benefit of the usual commissions under contracts with two companies. One contract referred to him as "agent" and the other as "broker."

The Commissioner of Internal Revenue claimed a tax based on the commissions allowed him on these policies, but the Tax Court, seven Judges dissenting, held that the taxpayer was in fact a broker and not an employee and hence under prevailing income tax regulations the sums in question were not specified to be income.

The Court of Appeals for the Fifth Court reversed the Tax Court, holding that the commissions allowed to the taxpayer were, in fact, income and that no distinction in this respect should be made between an agent and a broker. The Court seemed to put considerable weight on the fact that under Texas law insurance could not be sold at any discount.

The Court in its opinion stated:

> It cannot be said that the insurance had a value less than the amount of the premiums. It must then be said that a benefit inured to the taxpayer to the extent of his

commissions. The benefit is neither diminished nor eliminated by referring, as does the Tax Court, to the word "commission" as a verbal trap. The commissions were, we conclude, compensation for services and as such were income within the meaning of 26 U.S.C.A. (I.R.C. 1954) § 61(a)(1).

This result is not in keeping with practices in other businesses where an employee who receives a discount on a purchase is not chargeable with taxable income in the amount of the discount. The decision is in accord with a fairly recent holding in another circuit.

MISREPRESENTATION—NOTICE TO INSURER FROM ITS GROUP RECORDS: *Schrader v. Prudential Insurance Company* (C. A. 5, June 9, 1960) 280 F.2d 355. Schrader, an industrial agent of Prudential, was allowed hospital and surgical benefits under a Prudential policy on account of a malignant skin tumor removed in 1953 and disclosed at the time in the claim forms. About two years later he complained to his own doctor of tender masses and the doctor recommended that he see a surgeon. On the same day he signed an application for a $25,000 life policy in the Prudential, denying any illness. The Prudential examining physician approved him. The policy was issued and the next day he entered the hospital. He was operated on the following day for the cancerous condition which caused his death about a year and a half later. In the meanwhile he put in other disability claims under the Prudential disability policy, which claim forms likewise disclosed the malignant condition. Benefits were allowed to him.

After the insured died the Prudential refused payment of the face amount under its life insurance policy but offered to return the premiums paid plus interest. This the beneficiary refused to accept and she brought this suit. There was no question about fraudulent misrepresentations. This was conceded. The beneficiary's claim was that by reason of its knowledge from its records and otherwise the Prudential waived or was estopped to deny liability for the full amount. Her claim was that the examining physician of Prudential should have discovered the lump which was the subject of the operation two days later and, importantly, that Prudential was chargeable with knowledge of the malignant condition by reason of the fact that this was disclosed in the hospitalization claim forms submitted both before and after the life policy was issued.

There was extensive testimony as to the practice of Prudential in connection with handling of group claims, including particularly the fact that the information was never transferred to M.I.B. records. The District Court granted judgment for the Prudential notwithstanding a jury verdict against it, and the beneficiary took this appeal.

On appeal the Court of Appeals held that the Prudential was not chargeable with knowledge of what was contained in its file relating to group insurance. The Court stated:

A considerable part of the low cost of group hospitalization insurance is attributable to handling the insurance on a group basis and not on an individual basis. This Court is not willing to require that an insurance company go to the extra expense, passed on to policy holders by way of higher premiums, of handling health impairments in group in-

surance in the same manner as health impairments in individual insurance, where the applicant has consciously misrepresented the true facts in breach of his duty of good faith.

The Court discussed at length the obligation of an insurance agent to exercise good faith in dealing with his own company, citing cases holding that under such circumstances he would be held to a higher degree of responsibility. On this point the Court stated:

> Schrader answered fraudulently material questions in his application and accepted delivery of a policy when he knew that he was not in good health. The insurer did not waive its right to cancel, nor is it estopped to deny liability. Waiver and estoppel apply when the insured is deceived or misled to his detriment, not when an insured invokes waiver and estoppel in order to make his fraud effective. Viewing the evidence in a light most favorable to the plaintiff, we agree with the district judge that there was no evidence and no inference that might be reasonably drawn from the evidence that would sustain a recovery by the plaintiff.

In a case of flagrant misrepresentation or fraud the courts are reluctant to impose liability on the company, especially where, as here, the policy was on the agent's own life. The general rule is that a company is chargeable with knowledge of what its files contain, but here the Court refuses to apply this general rule to group insurance.

SIMILARITY OF NAMES—INJUNCTION ACTION: *Metropolitan Life Insurance Company v. Metropolitan Insurance Company* (C. A. 7, May 13, 1960) 277 F.2d 896. In October 1958 Highway Insurance Company, an Illinois casualty company, changed its name to Metropolitan Insurance Company. It filed the name change as required with the Director of Insurance of Illinois and in other states where it was licensed to do business. No notice of the name change was given Metropolitan Life Insurance Company by the Director of Insurance of Illinois.

Metropolitan Life Insurance Company brought this injunction action to prevent Metropolitan Insurance Company from using that name or any name containing the word "Metropolitan" or any other name deceptively similar. Metropolitan Insurance Company claimed that the proceeding should be brought through the Director of Insurance of Illinois under Illinois law and that there was no deception. The United States District Court granted the injunction in favor of Metropolitan Life Insurance Company as requested, and Metropolitan Insurance Company took this appeal.

On appeal the Court of Appeals for the Seventh Circuit affirmed the judgment of the District Court, stating:

> We hold that the record lends ample support to the findings that there is likelihood of confusion and deception in this case. This is dispositive of defendant's other contentions relating to the likelihood of confusion.
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> Finally, defendant contends that "Metropolitan" is a weak mark and that plaintiff cannot appropriate it to its exclusive use beyond the field of life insurance. We are not favorably impressed with this contention. The question before us is whether defendant's name is deceptively similar to that of plaintiff. No relief is sought against any other party. Whether other insurance companies use the word "Metropolitan" in their cor-

porate names is not relevant here. The propriety of such use in other situations would have to be determined on a case-by-case basis depending upon the circumstances surrounding each situation in a proper action.

Ofttimes the courts find it quite difficult to determine whether names are deceptively similar. Cases involving this point are quite frequent.

POLICY REFUSED—LIABILITY OF APPLICANT FOR COMMISSIONS: ***Friedman v. Markman*** (New York Appellate Division, First Department, June 14, 1960) 201 N.Y.S.2d 743. Friedman, a life insurance agent, procured a life insurance policy for Markman after Markman had previously been declined for life insurance. Markman refused to accept the policy or to pay the premium.

Friedman then commenced this action against Markman, claiming that Markman had made an agreement to accept a policy if available and to pay the premiums and had not fulfilled this agreement. He sued for commissions which would be payable for twenty years. Markman moved to dismiss the complaint on the basis that the complaint was not sufficient to state a cause of action and on the further basis that it was not to be performed within one year, was not in writing, and therefore was invalid under the "statute of frauds." The trial court refused to dismiss the action and Markman took this appeal.

On appeal the Appellate Division took the position that an applicant for insurance may decline to accept it and no premium is due because no risk has attached, that the insurance agent is ordinarily the agent of the company and not of the applicant, that the obligation to pay commissions is imposed on the company and not on the applicant, and that the New York law prohibits the payment of any compensation to a life insurance agent greater than that determined by an agreement made in advance of the payment of premiums. The Court also agreed with Markman that the agreement was void because it could not be performed within a year.

The Court in its opinion stated:

> If a life insurance agent be permitted to recover as damages the amount of commissions he would have received when a prospective insured rejects a life insurance policy, the effect is to impose a limitation and nullify the hitherto recognized right of either a life insurance company or the prospective insured to cancel, reject or refuse the policy at any time until the premium is paid. For all practical purposes it is an assurance of compensation to an agent when he alleges the existence of an agreement to accept a life insurance policy, though the agent is really doing only that for which he is originally employed, or for which he holds a certificate of authority. Such a guarantee is a form of extra compensation not contemplated by and, it would seem, within the prohibition of the statute.
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> The action here is grounded upon an alleged agreement to accept a life insurance policy and pay the premiums therefor. The answer denies such agreement. Implicit in every application for a life insurance policy is an understanding, which might or might not be considered as rising to the stature of a promise, that the applicant will accept and pay the premiums for the desired policy. Nothing is shown here to warrant the application of another or different rule from that usually applicable to life insurance policies, viz., the right of rejection.

It is usually assumed that an applicant who has not paid a binder may refuse to accept and pay for the policy.

DOUBLE INDEMNITY—PSYCHIC TRAUMA: *Pan American Life Insurance Company v. Andrews* (Texas Supreme Court, April 6, 1960) 340 S.W.2d 787. The life insurance policies provided double indemnity for death occurring as a result of bodily injuries effected "through external, violent, and accidental means" independent of other causes. The insured watched his office burn from a nearby building and became excited and died about a month later from a clot in an artery of the brain. During the interval between the fire and his death he had complained of various physical symptoms, including nervousness, a limp in his right leg, forgetfulness and other symptoms. Shortly before his death a neurosurgeon operated on his brain. This surgeon testified, "The fire produced the reaction in his mind, which is capable of producing damage to the cells tissue, not only in the brain, but other organs too."

The Pan American and the other company involved took the position that the insured did not die as a result of bodily injuries effected through external, violent, and accidental means, and independent of other causes, and hence denied liability for double indemnity benefits. The beneficiary brought suit and a judgment in her favor was entered. This judgment was affirmed on appeal to the intermediate appellate court and thereafter the companies took this appeal to the Texas Supreme Court.

The Texas Supreme Court first affirmed the judgment below by a six-to-three decision. Upon application for rehearing, that Court again affirmed the judgment below. This time, however, the Court was divided five to four. On another application for rehearing, one Justice shifted position. The Court then reversed the judgment below and rendered a decision in the Texas Supreme Court in favor of the insurance company.

In its major opinion the Court stated:

> Neither the fire nor the view of the fire can be said to be "accidental, external and violent," so far as insured is concerned any more than if he had read an account of the fire in the newspaper a week later or if he had been told of the fire and the destruction of his records during his absence from the city. Surely, under a reasonable interpretation of the contract it could not be said in those events that the insured had suffered bodily injuries as a result of external, violent and accidental means.

There was a vigorous dissenting opinion by the four Justices who dissented. The position of the dissenting Justices is thus stated:

> It is of no consequence whether the fire was accidental in origin or otherwise. The fire was not the *means* of the insured's death. The psychic trauma which resulted from viewing the fire was the *means* or *cause* of his death. The viewing of the fire was no accident; it was voluntary and deliberate. But the viewing of the fire produced a wholly unexpected, unusual and unforeseen catastrophe—a clot in an artery of the brain. And even if we may say that the reaction of extreme excitement flowing from witnessing the destruction of his office and records was not unusual, we are yet compelled to say, on the basis of petitioners' own medical testimony as well as from common knowledge, that the

generation of a cerebral arterio-thrombosis from the excitement was an unusual and unforeseen result. It cannot be a logical distinction between the drowning and asphyxiation cases and this case that whereas the external and violent force in those cases entered the body through the nose or the mouth and caused death by injury to other organs of the body the external and violent force in this case entered the body through the eyes and caused death by injury to the brain. We therefore hold that the death of the insured, under the evidence adduced in this case, was effected or produced by accidental means.

This case is illustrative of the growing tendency on the part of courts to hold the company liable under circumstances where obviously the company did not intend to cover the loss. Fortunately in this case a majority of the Justices finally decided that the company was not liable, but this decision came only after two applications for rehearing. The current practice of issuing large amounts of double indemnity may present future problems to an extent not now contemplated by the underwriters.