General Assembly

Raised Bill No. 343

February Session, 2020

LCO No. **1975**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING FINANCIAL PLANNERS AND THE CONNECTICUT UNFAIR INSURANCE PRACTICES ACT.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-1 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective October 1, 2020*):

3 Terms used in this title and section 2 of this act, unless it appears from
4 the context to the contrary, shall have a scope and meaning as set forth
5 in this section.

6 (1) "Affiliate" or "affiliated" means a person that directly, or indirectly
7 through one or more intermediaries, controls, is controlled by or is
8 under common control with another person.

9 (2) "Alien insurer" means any insurer that has been chartered by or
10 organized or constituted within or under the laws of any jurisdiction or
11 country without the United States.

12 (3) "Annuities" means all agreements to make periodical payments
13 where the making or continuance of all or some of the series of the

14 payments, or the amount of the payment, is dependent upon the
15 continuance of human life or is for a specified term of years. This
16 definition does not apply to payments made under a policy of life
17 insurance.

18 (4) "Commissioner" means the Insurance Commissioner.

19 (5) "Control", "controlled by" or "under common control with" means
20 the possession, direct or indirect, of the power to direct or cause the
21 direction of the management and policies of a person, whether through
22 the ownership of voting securities, by contract other than a commercial
23 contract for goods or nonmanagement services, or otherwise, unless the
24 power is the result of an official position with the person.

25 (6) "Domestic insurer" means any insurer that has been chartered by,
26 incorporated, organized or constituted within or under the laws of this
27 state.

28 (7) "Domestic surplus lines insurer" means any domestic insurer that
29 has been authorized by the commissioner to write surplus lines
30 insurance.

31 (8) "Foreign country" means any jurisdiction not in any state, district
32 or territory of the United States.

33 (9) "Foreign insurer" means any insurer that has been chartered by or
34 organized or constituted within or under the laws of another state or a
35 territory of the United States.

36 (10) "Insolvency" or "insolvent" means, for any insurer, that it is
37 unable to pay its obligations when they are due, or when its admitted
38 assets do not exceed its liabilities plus the greater of: (A) Capital and
39 surplus required by law for its organization and continued operation;
40 or (B) the total par or stated value of its authorized and issued capital
41 stock. For purposes of this subdivision "liabilities" shall include but not
42 be limited to reserves required by statute or by regulations adopted by
43 the commissioner in accordance with the provisions of chapter 54 or

44 specific requirements imposed by the commissioner upon a subject
45 company at the time of admission or subsequent thereto.

46 (11) "Insurance" means any agreement to pay a sum of money,
47 provide services or any other thing of value on the happening of a
48 particular event or contingency or to provide indemnity for loss in
49 respect to a specified subject by specified perils in return for a
50 consideration. In any contract of insurance, an insured shall have an
51 interest which is subject to a risk of loss through destruction or
52 impairment of that interest, which risk is assumed by the insurer and
53 such assumption shall be part of a general scheme to distribute losses
54 among a large group of persons bearing similar risks in return for a
55 ratable contribution or other consideration.

56 (12) "Insurer" or "insurance company" includes any person or
57 combination of persons doing any kind or form of insurance business
58 other than a fraternal benefit society, and shall include a receiver of any
59 insurer when the context reasonably permits.

60 (13) "Insured" means a person to whom or for whose benefit an
61 insurer makes a promise in an insurance policy. The term includes
62 policyholders, subscribers, members and beneficiaries. This definition
63 applies only to the provisions of this title and does not define the
64 meaning of this word as used in insurance policies or certificates.

65 (14) "Life insurance" means insurance on human lives and insurances
66 pertaining to or connected with human life. The business of life
67 insurance includes granting endowment benefits, granting additional
68 benefits in the event of death by accident or accidental means, granting
69 additional benefits in the event of the total and permanent disability of
70 the insured, and providing optional methods of settlement of proceeds.
71 Life insurance includes burial contracts to the extent provided by
72 section 38a-464.

73 (15) "Mutual insurer" means any insurer without capital stock, the
74 managing directors or officers of which are elected by its members.

75 (16) "Person" means an individual, a corporation, a partnership, a
76 limited liability company, an association, a joint stock company, a
77 business trust, an unincorporated organization or other legal entity.

78 (17) "Policy" means any document, including attached endorsements
79 and riders, purporting to be an enforceable contract, which
80 memorializes in writing some or all of the terms of an insurance
81 contract.

82 (18) "State" means any state, district, or territory of the United States.

83 (19) "Subsidiary" of a specified person means an affiliate controlled
84 by the person directly, or indirectly through one or more intermediaries.

85 (20) "Unauthorized insurer" or "nonadmitted insurer" means an
86 insurer that has not been granted a certificate of authority by the
87 commissioner to transact the business of insurance in this state or an
88 insurer transacting business not authorized by a valid certificate.

89 (21) "United States" means the United States of America, its territories
90 and possessions, the Commonwealth of Puerto Rico and the District of
91 Columbia.

92 Sec. 2. (NEW) (*Effective October 1, 2020*) (a) For the purposes of this
93 section:

94 (1) "Fiduciary duty" has the same meaning as provided in section 36a-
95 860 of the general statutes; and

96 (2) "Financial planner" has the same meaning as provided in section
97 36a-860 of the general statutes.

98 (b) A financial planner doing business in this state shall disclose to a
99 consumer in this state, upon request, whether or not such financial
100 planner has a fiduciary duty to such consumer for each
101 recommendation that such financial planner makes to such consumer
102 regarding insurance.

103 (c) Any violation of this section shall be deemed an unfair method of
104 competition and unfair and deceptive act or practice in the business of
105 insurance under section 38a-816 of the general statutes, as amended by
106 this act.

107 Sec. 3. Section 38a-816 of the 2020 supplement to the general statutes
108 is repealed and the following is substituted in lieu thereof (*Effective*
109 *October 1, 2020*):

110 The following are defined as unfair methods of competition and
111 unfair and deceptive acts or practices in the business of insurance:

112 (1) Misrepresentations and false advertising of insurance policies.
113 Making, issuing or circulating, or causing to be made, issued or
114 circulated, any estimate, illustration, circular or statement, sales
115 presentation, omission or comparison which: (A) Misrepresents the
116 benefits, advantages, conditions or terms of any insurance policy; (B)
117 misrepresents the dividends or share of the surplus to be received, on
118 any insurance policy; (C) makes any false or misleading statements as
119 to the dividends or share of surplus previously paid on any insurance
120 policy; (D) is misleading or is a misrepresentation as to the financial
121 condition of any person, or as to the legal reserve system upon which
122 any life insurer operates; (E) uses any name or title of any insurance
123 policy or class of insurance policies misrepresenting the true nature
124 thereof; (F) is a misrepresentation, including, but not limited to, an
125 intentional misquote of a premium rate, for the purpose of inducing or
126 tending to induce to the purchase, lapse, forfeiture, exchange,
127 conversion or surrender of any insurance policy; (G) is a
128 misrepresentation for the purpose of effecting a pledge or assignment of
129 or effecting a loan against any insurance policy; or (H) misrepresents
130 any insurance policy as being shares of stock.

131 (2) False information and advertising generally. Making, publishing,
132 disseminating, circulating or placing before the public, or causing,
133 directly or indirectly, to be made, published, disseminated, circulated or
134 placed before the public, in a newspaper, magazine or other publication,

135 or in the form of a notice, circular, pamphlet, letter or poster, or over any
136 radio or television station, or in any other way, an advertisement,
137 announcement or statement containing any assertion, representation or
138 statement with respect to the business of insurance or with respect to
139 any person in the conduct of his insurance business, which is untrue,
140 deceptive or misleading.

141 (3) Defamation. Making, publishing, disseminating or circulating,
142 directly or indirectly, or aiding, abetting or encouraging the making,
143 publishing, disseminating or circulating of, any oral or written
144 statement or any pamphlet, circular, article or literature which is false
145 or maliciously critical of or derogatory to the financial condition of an
146 insurer, and which is calculated to injure any person engaged in the
147 business of insurance.

148 (4) Boycott, coercion and intimidation. Entering into any agreement
149 to commit, or by any concerted action committing, any act of boycott,
150 coercion or intimidation resulting in or tending to result in unreasonable
151 restraint of, or monopoly in, the business of insurance.

152 (5) False financial statements. Filing with any supervisory or other
153 public official, or making, publishing, disseminating, circulating or
154 delivering to any person, or placing before the public, or causing,
155 directly or indirectly, to be made, published, disseminated, circulated or
156 delivered to any person, or placed before the public, any false statement
157 of financial condition of an insurer with intent to deceive; or making any
158 false entry in any book, report or statement of any insurer with intent to
159 deceive any agent or examiner lawfully appointed to examine into its
160 condition or into any of its affairs, or any public official to whom such
161 insurer is required by law to report, or who has authority by law to
162 examine into its condition or into any of its affairs, or, with like intent,
163 wilfully omitting to make a true entry of any material fact pertaining to
164 the business of such insurer in any book, report or statement of such
165 insurer.

166 (6) Unfair claim settlement practices. Committing or performing with

167 such frequency as to indicate a general business practice any of the
168 following: (A) Misrepresenting pertinent facts or insurance policy
169 provisions relating to coverages at issue; (B) failing to acknowledge and
170 act with reasonable promptness upon communications with respect to
171 claims arising under insurance policies; (C) failing to adopt and
172 implement reasonable standards for the prompt investigation of claims
173 arising under insurance policies; (D) refusing to pay claims without
174 conducting a reasonable investigation based upon all available
175 information; (E) failing to affirm or deny coverage of claims within a
176 reasonable time after proof of loss statements have been completed; (F)
177 not attempting in good faith to effectuate prompt, fair and equitable
178 settlements of claims in which liability has become reasonably clear; (G)
179 compelling insureds to institute litigation to recover amounts due under
180 an insurance policy by offering substantially less than the amounts
181 ultimately recovered in actions brought by such insureds; (H)
182 attempting to settle a claim for less than the amount to which a
183 reasonable man would have believed he was entitled by reference to
184 written or printed advertising material accompanying or made part of
185 an application; (I) attempting to settle claims on the basis of an
186 application which was altered without notice to, or knowledge or
187 consent of the insured; (J) making claims payments to insureds or
188 beneficiaries not accompanied by statements setting forth the coverage
189 under which the payments are being made; (K) making known to
190 insureds or claimants a policy of appealing from arbitration awards in
191 favor of insureds or claimants for the purpose of compelling them to
192 accept settlements or compromises less than the amount awarded in
193 arbitration; (L) delaying the investigation or payment of claims by
194 requiring an insured, claimant, or the physician of either to submit a
195 preliminary claim report and then requiring the subsequent submission
196 of formal proof of loss forms, both of which submissions contain
197 substantially the same information; (M) failing to promptly settle claims,
198 where liability has become reasonably clear, under one portion of the
199 insurance policy coverage in order to influence settlements under other
200 portions of the insurance policy coverage; (N) failing to promptly
201 provide a reasonable explanation of the basis in the insurance policy in

202 relation to the facts or applicable law for denial of a claim or for the offer
203 of a compromise settlement; (O) using as a basis for cash settlement with
204 a first party automobile insurance claimant an amount which is less than
205 the amount which the insurer would pay if repairs were made unless
206 such amount is agreed to by the insured or provided for by the
207 insurance policy.

208 (7) Failure to maintain complaint handling procedures. Failure of any
209 person to maintain complete record of all the complaints which it has
210 received since the date of its last examination. This record shall indicate
211 the total number of complaints, their classification by line of insurance,
212 the nature of each complaint, the disposition of these complaints, and
213 the time it took to process each complaint. For purposes of this
214 subsection "complaint" means any written communication primarily
215 expressing a grievance.

216 (8) Misrepresentation in insurance applications. Making false or
217 fraudulent statements or representations on or relative to an application
218 for an insurance policy for the purpose of obtaining a fee, commission,
219 money or other benefit from any insurer, producer or individual.

220 (9) Any violation of any one of sections 38a-358, 38a-446, 38a-447, 38a-
221 488, 38a-825, 38a-826, 38a-828 and 38a-829. None of the following
222 practices shall be considered discrimination within the meaning of
223 section 38a-446 or 38a-488 or a rebate within the meaning of section 38a-
224 825: (A) Paying bonuses to policyholders or otherwise abating their
225 premiums in whole or in part out of surplus accumulated from
226 nonparticipating insurance, provided any such bonuses or abatement of
227 premiums shall be fair and equitable to policyholders and for the best
228 interests of the company and its policyholders; (B) in the case of policies
229 issued on the industrial debit plan, making allowance to policyholders
230 who have continuously for a specified period made premium payments
231 directly to an office of the insurer in an amount which fairly represents
232 the saving in collection expense; (C) readjustment of the rate of premium
233 for a group insurance policy based on loss or expense experience, or
234 both, at the end of the first or any subsequent policy year, which may be

235 made retroactive for such policy year.

236 (10) Notwithstanding any provision of any policy of insurance,
237 certificate or service contract, whenever such insurance policy or
238 certificate or service contract provides for reimbursement for any
239 services which may be legally performed by any practitioner of the
240 healing arts licensed to practice in this state, reimbursement under such
241 insurance policy, certificate or service contract shall not be denied
242 because of race, color or creed nor shall any insurer make or permit any
243 unfair discrimination against particular individuals or persons so
244 licensed.

245 (11) Favored agent or insurer: Coercion of debtors. (A) No person
246 may (i) require, as a condition precedent to the lending of money or
247 extension of credit, or any renewal thereof, that the person to whom
248 such money or credit is extended or whose obligation the creditor is to
249 acquire or finance, negotiate any policy or contract of insurance through
250 a particular insurer or group of insurers or producer or group of
251 producers; (ii) unreasonably disapprove the insurance policy provided
252 by a borrower for the protection of the property securing the credit or
253 lien; (iii) require directly or indirectly that any borrower, mortgagor,
254 purchaser, insurer or producer pay a separate charge, in connection
255 with the handling of any insurance policy required as security for a loan
256 on real estate or pay a separate charge to substitute the insurance policy
257 of one insurer for that of another; or (iv) use or disclose information
258 resulting from a requirement that a borrower, mortgagor or purchaser
259 furnish insurance of any kind on real property being conveyed or used
260 as collateral security to a loan, when such information is to the
261 advantage of the mortgagee, vendor or lender, or is to the detriment of
262 the borrower, mortgagor, purchaser, insurer or the producer complying
263 with such a requirement.

264 (B) (i) Subparagraph (A)(iii) of this subdivision shall not include the
265 interest which may be charged on premium loans or premium
266 advancements in accordance with the security instrument. (ii) For
267 purposes of subparagraph (A)(ii) of this subdivision, such disapproval

268 shall be deemed unreasonable if it is not based solely on reasonable
269 standards uniformly applied, relating to the extent of coverage required
270 and the financial soundness and the services of an insurer. Such
271 standards shall not discriminate against any particular type of insurer,
272 nor shall such standards call for the disapproval of an insurance policy
273 because such policy contains coverage in addition to that required. (iii)
274 The commissioner may investigate the affairs of any person to whom
275 this subdivision applies to determine whether such person has violated
276 this subdivision. If a violation of this subdivision is found, the person in
277 violation shall be subject to the same procedures and penalties as are
278 applicable to other provisions of section 38a-815, subsections (b) and (e)
279 of section 38a-817 and this section. (iv) For purposes of this section,
280 "person" includes any individual, corporation, limited liability
281 company, association, partnership or other legal entity.

282 (12) Refusing to insure, refusing to continue to insure or limiting the
283 amount, extent or kind of coverage available to an individual or
284 charging an individual a different rate for the same coverage because of
285 physical disability, mental or nervous condition as set forth in section
286 38a-488a or intellectual disability, except where the refusal, limitation or
287 rate differential is based on sound actuarial principles or is related to
288 actual or reasonably anticipated experience.

289 (13) Refusing to insure, refusing to continue to insure or limiting the
290 amount, extent or kind of coverage available to an individual or
291 charging an individual a different rate for the same coverage solely
292 because of blindness or partial blindness. For purposes of this
293 subdivision, "refusal to insure" includes the denial by an insurer of
294 disability insurance coverage on the grounds that the policy defines
295 "disability" as being presumed in the event that the insured is blind or
296 partially blind, except that an insurer may exclude from coverage any
297 disability, consisting solely of blindness or partial blindness, when such
298 condition existed at the time the policy was issued. Any individual who
299 is blind or partially blind shall be subject to the same standards of sound
300 actuarial principles or actual or reasonably anticipated experience as are
301 sighted persons with respect to all other conditions, including the

302 underlying cause of the blindness or partial blindness.

303 (14) Refusing to insure, refusing to continue to insure or limiting the
304 amount, extent or kind of coverage available to an individual or
305 charging an individual a different rate for the same coverage because of
306 exposure to diethylstilbestrol through the female parent.

307 (15) (A) Failure by an insurer, or any other entity responsible for
308 providing payment to a health care provider pursuant to an insurance
309 policy, to pay accident and health claims, including, but not limited to,
310 claims for payment or reimbursement to health care providers, within
311 the time periods set forth in subparagraph (B) of this subdivision, unless
312 the Insurance Commissioner determines that a legitimate dispute exists
313 as to coverage, liability or damages or that the claimant has fraudulently
314 caused or contributed to the loss. Any insurer, or any other entity
315 responsible for providing payment to a health care provider pursuant
316 to an insurance policy, who fails to pay such a claim or request within
317 the time periods set forth in subparagraph (B) of this subdivision shall
318 pay the claimant or health care provider the amount of such claim plus
319 interest at the rate of fifteen per cent per annum, in addition to any other
320 penalties which may be imposed pursuant to sections 38a-11, 38a-25,
321 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64,
322 inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129
323 to 38a-140, inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to
324 38a-290, inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819,
325 inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830,
326 inclusive. Whenever the interest due a claimant or health care provider
327 pursuant to this section is less than one dollar, the insurer shall deposit
328 such amount in a separate interest-bearing account in which all such
329 amounts shall be deposited. At the end of each calendar year each such
330 insurer shall donate such amount to The University of Connecticut
331 Health Center.

332 (B) Each insurer or other entity responsible for providing payment to
333 a health care provider pursuant to an insurance policy subject to this
334 section, shall pay claims not later than:

335 (i) For claims filed in paper format, sixty days after receipt by the
336 insurer of the claimant's proof of loss form or the health care provider's
337 request for payment filed in accordance with the insurer's practices or
338 procedures, except that when there is a deficiency in the information
339 needed for processing a claim, as determined in accordance with section
340 38a-477, the insurer shall (I) send written notice to the claimant or health
341 care provider, as the case may be, of all alleged deficiencies in
342 information needed for processing a claim not later than thirty days
343 after the insurer receives a claim for payment or reimbursement under
344 the contract, and (II) pay claims for payment or reimbursement under
345 the contract not later than thirty days after the insurer receives the
346 information requested; and

347 (ii) For claims filed in electronic format, twenty days after receipt by
348 the insurer of the claimant's proof of loss form or the health care
349 provider's request for payment filed in accordance with the insurer's
350 practices or procedures, except that when there is a deficiency in the
351 information needed for processing a claim, as determined in accordance
352 with section 38a-477, the insurer shall (I) notify the claimant or health
353 care provider, as the case may be, of all alleged deficiencies in
354 information needed for processing a claim not later than ten days after
355 the insurer receives a claim for payment or reimbursement under the
356 contract, and (II) pay claims for payment or reimbursement under the
357 contract not later than ten days after the insurer receives the information
358 requested.

359 (C) As used in this subdivision, "health care provider" means a person
360 licensed to provide health care services under chapter 368d, chapter
361 368v, chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c,
362 inclusive, or chapter 400j.

363 (16) Failure to pay, as part of any claim for a damaged motor vehicle
364 under any automobile insurance policy where the vehicle has been
365 declared to be a constructive total loss, an amount equal to the sum of
366 (A) the settlement amount on such vehicle plus, whenever the insurer
367 takes title to such vehicle, (B) an amount determined by multiplying

368 such settlement amount by a percentage equivalent to the current sales
369 tax rate established in section 12-408. For purposes of this subdivision,
370 "constructive total loss" means the cost to repair or salvage damaged
371 property, or the cost to both repair and salvage such property, equals or
372 exceeds the total value of the property at the time of the loss.

373 (17) Any violation of section 42-260, by an extended warranty
374 provider subject to the provisions of said section, including, but not
375 limited to: (A) Failure to include all statements required in subsections
376 (c) and (f) of section 42-260 in an issued extended warranty; (B) offering
377 an extended warranty without being (i) insured under an adequate
378 extended warranty reimbursement insurance policy or (ii) able to
379 demonstrate that reserves for claims contained in the provider's
380 financial statements are not in excess of one-half the provider's audited
381 net worth; (C) failure to submit a copy of an issued extended warranty
382 form or a copy of such provider's extended warranty reimbursement
383 policy form to the Insurance Commissioner.

384 (18) With respect to an insurance company, hospital service
385 corporation, health care center or fraternal benefit society providing
386 individual or group health insurance coverage of the types specified in
387 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469,
388 refusing to insure, refusing to continue to insure or limiting the amount,
389 extent or kind of coverage available to an individual or charging an
390 individual a different rate for the same coverage because such
391 individual has been a victim of family violence.

392 (19) With respect to an insurance company, hospital service
393 corporation, health care center or fraternal benefit society providing
394 individual or group health insurance coverage of the types specified in
395 subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469,
396 refusing to insure, refusing to continue to insure or limiting the amount,
397 extent or kind of coverage available to an individual or charging an
398 individual a different rate for the same coverage because of genetic
399 information. Genetic information indicating a predisposition to a
400 disease or condition shall not be deemed a preexisting condition in the

401 absence of a diagnosis of such disease or condition that is based on other
402 medical information. An insurance company, hospital service
403 corporation, health care center or fraternal benefit society providing
404 individual health coverage of the types specified in subdivisions (1), (2),
405 (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, shall not be
406 prohibited from refusing to insure or applying a preexisting condition
407 limitation, to the extent permitted by law, to an individual who has been
408 diagnosed with a disease or condition based on medical information
409 other than genetic information and has exhibited symptoms of such
410 disease or condition. For the purposes of this subsection, "genetic
411 information" means the information about genes, gene products or
412 inherited characteristics that may derive from an individual or family
413 member.

414 (20) Any violation of sections 38a-465 to 38a-465q, inclusive.

415 (21) With respect to a managed care organization, as defined in
416 section 38a-478, failing to establish a confidentiality procedure for
417 medical record information, as required by section 38a-999.

418 (22) Any violation of sections 38a-591d to 38a-591f, inclusive.

419 (23) Any violation of section 38a-472j.

420 <u>(24) Any violation of section 2 of this act.</u>

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2020*	38a-1
Sec. 2	*October 1, 2020*	New section
Sec. 3	*October 1, 2020*	38a-816

Statement of Purpose:

To: (1) Require each financial planner doing business in this state to disclose to a consumer in this state, upon request, whether or not such financial planner has a fiduciary duty to such consumer for each recommendation that such financial planner makes to such consumer regarding insurance; and (2) provide that any failure to make such

disclosure constitutes a violation of the Connecticut Unfair Insurance Practices Act.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]