§ 4724. Unfair methods of competition or unfair or deceptive acts or practices defined

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

(1) Misrepresentations and false advertising of insurance policies. Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison which:

(A) misrepresents or fails to adequately disclose the benefits, advantages, conditions, exclusions, limitations, or terms of any insurance policy; or

(B) misrepresents the dividends or share of the surplus to be received on any insurance policy; or

(C) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; or

(D) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates; or

(E) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; or

(F) is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy; or

(G) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(H) misrepresents any insurance policy as being shares of stock.

(2) False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public or causing, directly or

indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, in the form of a notice, circular, pamphlet, letter, or poster or over any radio station or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his or her business, which is untrue, deceptive, or misleading.

(3) Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person and which is calculated to injure such person.

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

(B) Committing any act of boycott, coercion, or intimidation in the marketing or sale of any insurance contracts.

(5) False financial statements and entries.

(A) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

(B) Knowingly making any false entry of a material fact in a book, report, or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report, or statement of such person.

(C) Knowingly concealing, withholding or destroying, mutilating, altering, or by any means falsifying any documentary material in the possession, custody, or control of any person after that person:

(i) has received a complaint to which that documentary material is directly relevant; or

(ii) knows that the documentary material is relevant to an investigation or an examination of that person being made by the Commissioner.

(6) Stock operations and advisory board contracts. Permitting agents, officers, or employees to issue or deliver agency or company stock or other capital stock, or benefit certificates or share in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insure.

(7) Unfair discrimination; arbitrary underwriting action.

(A) Making or permitting any unfair discrimination between insureds of the same class and equal risk in the rates charged for any contract of insurance, or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contracts.

(B) Making or permitting unfair discrimination against an applicant or an insured, on the basis of the sex, sexual orientation, gender identity, or marital status of the applicant or insured, with regard to:

(i) Underwriting standards and practices or eligibility requirements; or

(ii) Rates; however, nothing in this subdivision shall prevent any person who contracts to insure another from setting rates for such insurance in accordance with reasonable classifications based on relevant actuarial data or actual cost experience in accordance with section 4656 of this title.

(C)(i) Inquiring or investigating, directly or indirectly as to an applicant's, an insured's or a beneficiary's sexual orientation, or gender

identity in an application for insurance coverage, or in an investigation conducted by an insurer, reinsurer, or insurance support organization in connection with an application for such coverage, or using information about gender, marital status, medical history, occupation, residential living arrangements, beneficiaries, zip codes, or other territorial designations to determine sexual orientation or gender identity;

(ii) Using sexual orientation, gender identity, or beneficiary designation in the underwriting process or in the determination of insurability;

(iii) Making adverse underwriting decisions because medical records or a report from an insurance support organization reveal that an applicant or insured has demonstrated AIDS-related concerns by seeking counseling from health care professionals;

(iv) Making adverse underwriting decisions on the basis of the existence of nonspecific blood code information received from the medical information bureau or a national data bank, but this prohibition shall not bar investigation in response to such a nonspecific blood code;

(v) The provisions of this subdivision (C) shall not be construed to prohibit an insurer from requesting an applicant or insured to take an HIV-related test on the basis of the health history or current condition of health of the applicant or insured in accordance with the provisions of subdivision (20) of this section.

(D) Making or permitting any unfair discrimination against any individual by conditioning insurance rates, the provision or renewal of insurance coverage, or other conditions of insurance based on medical information, including the results of genetic testing, where there is not a relationship between the medical information and the cost of the insurance risk that the insurer would assume by insuring the proposed insured. In demonstrating the relationship, the insurer can rely on actual or reasonably anticipated experience. As used in this subdivision, "genetic testing" shall be defined as the term is defined in 18 V.S.A. § 9331(7).

(E) Making or permitting unfair discrimination between married couples and parties to a civil union as defined under 15 V.S.A. § 1201, with regard to the offering of insurance benefits to a couple, a spouse, a party to a civil union, or their family. The Commissioner shall adopt rules necessary to carry out the purposes of this subdivision. The rules shall ensure that insurance contracts and policies offered to married couples, spouses, and families are also made available to parties to a civil union and their families. The Commissioner may adopt by order standards and a process to bring the forms currently on file and approved by the Department into compliance with Vermont law. The standards and process may differ from the provisions contained in chapter 101, subchapter 6, and sections 4062, 4201, 4515a, 4587, 4685, 4687, 4688, 4985, 5104, and 8005 of this title where, in the Commissioner's opinion, the provisions regarding filing and approval of forms are not desirable or necessary to effectuate the purposes of this section.

(8) Rebates.

(A) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of insurance or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, any rebate or premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance contract or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever of value not specified in the contract.

(B) Making available through any rating plan or form, property, casualty, or surety insurance to any firm, corporation, or association of individuals, any preferred rate or premium based upon any fictitious grouping of such firm, corporation, or individuals. The grouping of risks by way of

membership, nonmembership, license, franchise, employment, contract, agreement, or any other method or means, when the grouping of risks have no preferred characteristic over similar risks written on an individual basis, for the purpose of insuring such grouped risks at a preferred rate or premium or on a preferred form is a "fictitious grouping." This subdivision shall not apply to life or health and disability insurance or annuity contracts.

(C) Nothing in subdivision (7) or (8)(A) of this section shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that such bonuses or abatement of premiums shall be fair, and equitable to policyholders and for the best interest of the company and its policyholders;

(ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses;

(iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(9) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a business practice any of the following:

(A) misrepresenting pertinent facts or insurance policy provisions relating to coverage at issue;

(B) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(C) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(D) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(E) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(F) not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(G) attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made a part of the application;

(H) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(I) making claim payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are made;

(J) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(K) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(L) failing to promptly settle claims where liability has become reasonably clear under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

(M) failing to promptly provide a reasonable explanation on the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) Failure to maintain complaint handling procedures. Failure of any person to maintain a complete record of all of the complaints which it has received since the date of its last examination under section 3563 or 3564 of this title. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, the time it took to process each complaint, and such other information as the Commissioner may require. As used in this subdivision, "complaint" shall mean any written communication primarily expressing a grievance.

(11) Misrepresentation in insurance applications. Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money, or other benefit from any insurers, agent, broker, or individual.

(12) Failure of agent, broker, or insurer to act as fiduciary. Failure of any insurance agent, broker, or insurer to act as a fiduciary in regard to premiums, return premiums or other sums of money received by him or her in his or her capacity as insurance agent, insurance broker, or insurer by failure to pay or transmit in a timely manner those sums of money to the persons to whom it is owed.

(13) Misrepresentation of services or products. Any person offering his or her, or its services or insurance policies to the public in such a way as to mislead or to fail to adequately disclose to the public the true nature of the policies or the services offered.

(14) Nondisclosure of fees or charges. Failure of any agent or broker to obtain a prior written agreement with a client, policyholder, or other member of the public concerning fees or charges made by that agent or broker directly to the client, policyholder, or member of the public for that agent or broker procuring, servicing, or providing advice on insurance contracts.

Commissions, expense allowances, bonuses, fees, or any other compensation received directly by agents or brokers from any legal entity engaged in the insurance business is exempt from this subdivision.

(15) Financed premiums. Misrepresenting or failing to completely disclose the terms, conditions, or benefits of financing premiums for insurance policies where the financing of the premiums constitute part of the solicitation or sale of the policy.

(16) Unsuitable policies. Soliciting, selling, or issuing an insurance policy when the person soliciting, selling, or issuing the policy has reason to know or should have reason to know that it is unsuitable for the person purchasing it.

(17) Failure to instruct or supervise representatives. Failure of an employer or principal engaged in the business of insurance to instruct or supervise any full-time agent, or full-time adjuster, or full or part-time employee after that employer or principal has knowledge of a deceptive or unfair act or practice prohibited by this chapter which was committed by that agent, adjuster, or employee.

(18) Doing business with a person known to be committing deceptive or unfair acts or using prohibited practices. Accepting business from or contracting with or continuing contractual relations with a person whom the other person knows or has or should have reason to know is repeatedly committing deceptive or unfair acts or practices prohibited by this title.

(19) Failure to comply with filed rates, rules, regulations, or forms. Failure to comply with any rates, rules, regulations, or forms filed with the Commissioner.

(20) HIV-related tests. Failing to comply with the provisions of this subdivision regarding HIV-related tests. "HIV-related test" means a test approved by the United States Food and Drug Administration and the Commissioner, used to determine the existence of HIV antibodies or antigens in the blood, urine, or oral mucosal transudate (OMT).

(A) No person shall request or require that a person reveal having taken HIV-related tests in the past.

(B)(i) No person shall request or require that an individual submit to an HIV-related test unless he or she has first obtained the individual's written informed consent to the test. Before written, informed consent may be granted, the individual shall be informed, by means of a printed information statement which shall have been read aloud to the individual by any agent of the insurer at the time of application or later and then given to the individual for review and retention, of the following:

(I) an explanation of the test or tests to be given, including: the tests' relationship to AIDS, the insurer's purpose in seeking the test, potential uses and disclosures of the results, limitations on the accuracy of and the meaning of the test's results, the importance of seeking counseling about the individual's test results after those results are received, and the availability of information from and the telephone numbers of the Vermont AIDS hotline and the Centers for Disease Control and Prevention; and

(II) an explanation that the individual is free to consult, at personal expense, with a personal physician or counselor or the State Department of Health, or obtain an anonymous test at the individual's choice and personal expense, before deciding whether to consent to testing and that such delay will not affect the status of any application or policy; and

(III) a summary of the individual's rights under this subdivision (20), including subdivisions (F)-(K); and

(IV) an explanation that the person requesting or requiring the test, not the individual or the individual's health care provider, will be billed for the test, that the individual has a choice to receive the test results directly or to designate in writing prior to the administration of the test any other person through whom to receive the results, and any HIV positive test result from a test performed pursuant to this subdivision (20) shall be reported to the Vermont Department of Health pursuant to 18 V.S.A. § 1001.

(ii) In addition, before drawing blood or obtaining a sample of the urine or OMT for the HIV-related test or tests, the person doing so shall give the individual to be tested an informed consent form containing the information required by the provisions of this subdivision (B), and shall then obtain the individual's written informed consent. If an OMT test is administered in the presence of the agent or broker, the individual's written informed consent need only be obtained prior to administering the test, in accordance with the provisions of this subdivision (B).

(C)(i) The forms for informed consent, information disclosure, and test results disclosure used for HIV-related testing shall be filed with and approved by the Commissioner pursuant to section 3541 of this title; and

(ii) Any testing procedure shall be filed and approved by the Commissioner in consultation with the Commissioner of Health.

(D) No laboratory may be used by an insurer or insurance support organization for the processing of HIV-related tests unless it is approved by the Vermont Department of Health. Any requests for approval under this subdivision shall be acted upon within 120 days. The Department may approve a laboratory without on-site inspection or additional proficiency data if the laboratory has been certified under the Clinical Laboratory Improvement Act, 42 U.S.C. § 263a or if it meets the requirements of the federal Health Care Financing Administration under the Clinical Laboratory Improvement Amendments.

(E) The test protocol shall be considered positive only if test results are two positive ELISA tests, and a Western Blot test confirms the results of the two ELISA tests, or upon approval of any equally or more reliable confirmatory test or test protocol which has been approved by the Commissioner and the U.S. Food and Drug Administration. If the result of any test performed on a sample of urine or OMT is positive or indeterminate, the insurer shall provide to the individual, no later than 30 days following the date of the first urine or OMT test results, the opportunity to retest once, and the individual shall have the option to provide either a blood sample, a urine sample, or an OMT

sample for that retest. This retest shall be in addition to the opportunities for retest provided in subdivisions (F) and (G) of this subdivision (20).

(F) If an individual has at least two positive ELISA tests but an indeterminate Western Blot test result, the Western Blot test may be repeated on the same sample. If the Western Blot test result is indeterminate, the insurer may delay action on the application, but no change in preexisting coverage, benefits, or rates under any separate policy or policies held by the individual may be based upon such indeterminacy. If action on an application is delayed due to indeterminacy as described herein, the insurer shall provide the individual the opportunity to retest once after six but not later than eight months following the date of the first indeterminate test result. If the retest Western Blot test result is again indeterminate or is negative, the test result shall be considered as negative, and a new application for coverage shall not be denied by the insurer based upon the results of either test. Any underwriting decision granting a substandard classification or exclusion based on the individual's prior HIV-related test results shall be reversed, and the company performing a retest which had forwarded to a medical information bureau reports based upon the individual's prior HIV-related test results shall request the medical information bureau to remove any abnormal codes listed due to such prior test results.

(G)(i) Upon the written request of an individual for a retest, an insurer shall retest, at the insurer's expense, any individual who was denied insurance, or offered insurance on any other than a standard basis, because of the positive results of an HIV-related test:

(I) once within the three-year period following the date of the most recent test; and

(II) in any event, upon the approval by the Commissioner of an alternative test or test protocol for the presence of HIV antibodies or antigens.

(ii) If such retest is negative, a new application for coverage shall not be denied by the insurer based upon the results of the initial test. Any underwriting decision granting a substandard classification or exclusion based

on the individual's prior HIV-related test results shall be reversed, and the company performing a retest which had forwarded to a medical information bureau reports based upon the individual's prior HIV-related test results shall request the medical information bureau to remove any abnormal codes listed due to such prior test results.

(H) An insurer, on the basis of the individual's written informed consent as specified in subdivision (B) of this subdivision, if necessary to make underwriting decisions regarding the particular individual's application, may disclose the results of an individual's HIV-related test results to its reinsurers, or to those contractually retained medical personnel, laboratories, insurance support organizations, and insurance affiliates (but not agents or brokers) that are involved in underwriting decisions regarding the individual's particular application. Other than the disclosures permitted by this subdivision, the entities listed herein, including the insurer, shall not further disclose to anyone individually identified HIV-related test result information without a separately obtained written authorization from the individual; provided, however, that if an individual's test result is positive or indeterminate, then an insurer may report a code to the medical information bureau provided that a nonspecific test result code is used which does not indicate that the individual was subjected to HIV-related testing.

(I) An insurer, reinsurer, contractually retained medical personnel, laboratories, medical information bureau, or other national data bank, insurance affiliate, or insurance support organizations that are obligated not to disclose any individually-identifiable records of HIV-related tests pursuant to this subdivision (20) shall have no duty to disclose this information to any person except in compliance with a court order or as provided in subdivision (B) or (H) nor shall it have any liability to any person for refusing or failing to disclose such information.

(J) Any individual who sustains damage as a result of the unauthorized negligent or knowing disclosure of that individual's individually-identifiable HIV-related test result information in violation of subdivision (H) of this subdivision (20) may bring an action for appropriate relief in Superior Court

against any person making such a disclosure. The Court may award costs and reasonable attorney's fees to the individual who prevails in an action brought under this subdivision.

(K) In addition to any other remedy or sanction provided by law, after notice and opportunity for hearing the Commissioner may assess an administrative penalty in an amount not to exceed $2,000.00 for each violation against any person who violates any provision of this subdivision (20) or subdivision (7)(C) of this section.

(21) Automobile glass services. In the case of claims for damage to automobile glass under a policy of insurance covering, in whole or in part, motor vehicles:

(A) Failing to inform an insured, at the time a claim is made, of the right of the insured to choose freely any company or location for providing automobile glass services.

(B) Intimidating, coercing, threatening, or misinforming an insured for the purpose of inducing the insured to use a particular company or location to provide automobile glass services.

(22) Genetic testing.

(A) Conditioning insurance rates, the provision or renewal of insurance coverage or benefits or other conditions of insurance for any individual on:

(i) any requirement or agreement of the individual to undergo genetic testing; or

(ii) the results of genetic testing of a member of the individual's family unless the results are contained in the individual's medical record.

(B) As used in this subdivision, "genetic testing" shall be defined as the term is defined in 18 V.S.A. § 9331(7). (Amended 1967, No. 186, eff. April 17, 1967; 1973, No. 216 (Adj. Sess.), § 4, eff. May 1, 1974; 1975, No. 180 (Adj. Sess.); 1979, No. 28, § 5; 1987, No. 194 (Adj. Sess.), §§ 1, 2; 1991, No. 135 (Adj. Sess.), § 7; 1991, No. 194 (Adj. Sess.); 1997, No. 160 (Adj. Sess.), § 5a,

eff. Jan. 1, 1999; 1999, No. 91 (Adj. Sess.), § 17, eff. Jan. 1, 2001; 2001, No. 23, § 1; 2007, No. 41, § 9; 2007, No. 73, § 3, eff. April 1, 2008.)