Unfair Insurance Practices Act

Title 40 P.S. Insurance
Chapter 4. Unfair Practices
Unfair Insurance Practices Act

Section 1171.1. Short title

This act shall be known and may be cited as the "Unfair Insurance Practices Act."

Section 1171.2. Declaration of purpose

The purpose of this act is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining or providing for the determination of all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

Section 1171.3. Definitions

As used in this act:

"Abuse" has the meaning given in 23 Pa.C.S. § 6102(a) (relating to definitions), notwithstanding the limited applicability provision in paragraph (5) of the definition of "abuse" in 23 Pa.C.S. § 6102(a). The term also means attempting to cause or intentionally, knowingly or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person covered under 23 Pa.C.S. Ch. 61 (relating to protection from abuse).

"Commissioner" means the insurance commissioner of the Commonwealth of Pennsylvania.

"Family or household members" has the meaning given in 23 Pa.C.S. § 6102(a) (relating to definitions).

"Insurance policy" or "Insurance Contract" means any contract of insurance, indemnity, health care, suretyship, title insurance, or annuity issued, proposed for issuance or intended for issuance by any person.

"Person" means any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds insurer, fraternal benefit society, beneficial association and any other legal entity engaged in the business of insurance, including agents, brokers and adjusters and also means health care plans. As defined in 40 Pa.C.S.A. Ch. 61 relating to hospital plan corporations, 40 Pa.C.S.A. Ch. 63 relating to professional health services plan corporations, 40 Pa.C.S.A. Ch.

65 relating to fraternal and beneficial societies 40 Pa.C.S.A., Ch. 67 relating to beneficial societies and the act of December 29, 1972 (P.L. 1701, No. 364), known as the "Voluntary Nonprofit Health Service Act of 1972." For purposes of this act, health care plans, fraternal benefit societies and beneficial societies shall be deemed to be engaged in the business of insurance.

"Renewal" or "to renew" means the issuance and delivery by an insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer, such renewal policy to provide types and limits of coverage at least equal to those contained in the policy being superseded, or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term with types and limits of coverage at least equal to those contained in the policy being extended: Provided, however, That any policy with a policy period or term of less than twelve months or any period with no fixed expiration date shall for the purpose of this act be considered as if written for successive policy periods or terms of twelve months.

"Victim" means an individual who is or has been subjected to abuse.

"Victim of abuse" means an individual who is a victim or an individual who seeks or has sought medical or psychological treatment for abuse, protection from abuse or shelter from abuse.

Section 1171.4. Unfair methods of competition and unfair or deceptive acts or practices prohibited

No person shall engage in this state in any trade practice which is defined or determined to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance pursuant to this act.

Section 1171.5. Unfair methods of competition and unfair or deceptive acts or practices defined

(a) "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means:

(1) Making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which:
(i) Misrepresents the benefits, advantages, conditions or terms of any insurance policy;
(ii) Misrepresents the premium overcharge commonly called dividends or share of the surplus to be received on any insurance policy;
(iii) Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy;
(iv) Is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any insurer operates;

(v) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;
(vi) Is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion or surrender of any insurance policy;
(vii) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or
(viii) Misrepresents any insurance policy as being shares of stock.

(2) Making, issuing, publishing or circulating in any manner an advertisement, announcement or statement containing any representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business which is untrue, deceptive or misleading.

(3) Making, issuing, publishing or circulating any oral or written statement 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) Entering into any agreement to commit, or by any concerted action committing, any act or boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(5) Knowingly filing with any supervisory or other public official, or knowingly making, issuing, publishing or circulating any false material statement of fact as to the financial condition of a person, or knowingly making any false entry of a material fact in any 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.

(6) Issuing or delivering or permitting agents, officers or employees to issue or deliver agency company stock or other capital stock, or benefit certificates or shares 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 insurance.

(7) Unfairly discriminating by means of:
(i) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract; or
(ii) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy, fees or rates charged for any policy or contract of insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.
(iii) Making or permitting any unfair discrimination between individuals of the same class and essentially the same hazard with regard to underwriting

standards and practices or eligibility requirements by reason of race, religion, nationality or ethnic group, age, sex, family size, occupation, place of residence or marital status. The terms "underwriting standards and practices" or "eligibility rules" do not include the promulgation of rates if made or promulgated in accordance with the appropriate rate regulatory act of this commonwealth and regulations promulgated by the commissioner pursuant to such act.

(8) 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 as inducement to such insurance, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration, inducement or anything of value whatsoever which is not specified in the contract.

(9) Cancelling any policy of insurance covering owner-occupied private residential properties or personal property of individuals that has been in force for sixty days or more or refusing to renew any such policy unless the policy was obtained through material misrepresentation, fraudulent statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by the company; or there has been a substantial change or increase in hazard in the risk assumed by the company subsequent to the date the policy was issued; or there is a substantial increase in hazards insured against by reason of wilful or negligent acts or omissions by the insured; or the insured has failed to pay any premium when due whether such premium is payable directly to the company or its agent or indirectly under any premium finance plan or extension of credit; or for any other reasons approved by the commissioner pursuant to rules and regulations promulgated by the commissioner. No cancellation or refusal to renew by any person shall be effective unless a written notice of the cancellation or refusal to renew is received by the insured either at the address shown in the policy or at a forwarding address. Such notice shall:

(i) Be approved as to form by the insurance commissioner prior to use.

(ii) State the date, not less than thirty days after the date of delivery or mailing on which such cancellation or refusal to renew shall become effective.

(iii) State the specific reason or reasons of the insurer for cancellation or refusal to renew.

(iv) Advise the insured of his right to request, in writing, within ten days of the receipt of the notice of cancellation or intention not to renew that the insurance commissioner review the action of the insurer.

(v) Advise the insured of his possible eligibility for insurance under the act of July 31, 1968 (P.L. 738, No. 233), known as "The Pennsylvania Fair Plan Act," [FN1] or the Pennsylvania Assigned Risk Plan.

(vi) Advise the insured in a form commonly understandable of the provisions of subparagraphs (ii), (iii) and (iv) of this paragraph as they limit permissible time and reasons for cancellation.

(vii) Advise the insured of the procedures to be followed in prosecuting an

appeal.

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

(i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

(v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

(vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.

(vii) Compelling persons to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts due and ultimately recovered in actions brought by such persons.

(viii) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(ix) Attempting to settle or compromise claims on the basis of an application which was altered without notice to or knowledge or consent of the insured of such alteration at the time such alteration was made.

(x) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made.

(xi) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants to induce or compel them to accept settlements or compromises less than the amount awarded in arbitration.

(xii) Delaying the investigation or payment of claims by requiring the 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.

(xiii) 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 or under other policies of insurance.

(xiv) Failing to promptly provide a reasonable explanation of 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.

(xv) Refusing payment of a claim solely on the basis of an insured's request to do so unless:

(a) The insured claims sovereign, eleemosynary, diplomatic, military service, or other immunity from suit or liability with respect to such claim;
(b) The insured is granted the right under the policy of insurance to consent to settlement of claims; or
(c) The refusal of payment is based upon the insurer's independent evaluation of the insured's liability based upon all available information.

(11) Failure of any person to maintain a complete record of all the complaints which it has received during the preceding four years. 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 and the time it took to process each complaint. For purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance.

(12) 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.

(13) Making, issuing, publishing or circulating in any manner an advertisement, announcement or statement offering permanent life insurance to persons fifty years of age or older without accompanying disclosures of any applicable reduction in the face amount payable and the period thereof.

(14) (i) Taking any of the following actions because the insured or applicant for an insurance policy or insurance contract is a victim of abuse:
(A) Denying, refusing to issue, refusing to renew, refusing to reissue or cancelling or terminating an insurance policy or insurance contract or restricting coverage under an insurance policy or insurance contract.
(B) Adding a surcharge, applying a rating factor or using any other underwriting standard or practice which adversely takes into account a history or status of abuse.
(C) Excluding or limiting benefits or coverage under an insurance policy or insurance contract for losses incurred.
(D) With respect to a policy of a private passenger automobile, a policy covering owner-occupied private residential property or a policy covering personal property of individuals, refusing to pay an insured for losses arising out of abuse to that insured under a property and casualty insurance policy or contract to the extent of the insured's legal interest in the covered property if the loss is caused by the intentional act of another insured or using other exclusions or limitations which the commissioner has determined unreasonably restrict the ability of victims of abuse to be indemnified for such losses. When an insured submits a claim for losses pursuant to this subsection, the insurer shall provide to the insured a notice stating:
(I) that the insurer cannot refuse to pay a claim without conducting a reasonable investigation;
(II) that such investigation may include or result in contact with other insureds;

(III) that at the request of the insured, the insurer will not disclose the location of the insured to the other insureds or third parties as part of the investigation;
(IV) that the insurer will notify the insured at least fourteen days prior to instituting any legal action against the insured alleged to have caused the loss;
(V) that, after an insurer has paid a loss as a result of the claim, the insurer may nonrenew coverage or impose a surcharge as to the insured alleged to have caused the loss as long as the nonrenewal or surcharge imposition is not done prior to the later of six months following payment of the claim or the policy's renewal date; and
(VI) the national domestic violence hotline number.

(ii) Nothing in this paragraph shall be construed as:
(A) requiring that a person issue, renew or reissue an insurance policy or insurance contract solely because the insured or applicant is a victim of abuse; or
(B) requiring a person to provide benefits or coverage for losses incurred solely because the insured or applicant is a victim of abuse.
(ii.1) Payment of a claim pursuant to subparagraph (i)(D) shall constitute payment as to all other insureds under the policy.

(iii) A person shall not be in violation of this paragraph if any action taken is permissible by law and applies to the same extent to all applicants and insureds without regard to whether an applicant or insured is a victim of abuse.

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

(1) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums out of surplus accumulated from nonparticipating insurance if any such bonuses or abatement of premiums are fair and equitable to policyholders and for the best interests of the company and its policyholders;
(2) In the case of life insurance policies issued on the industrial or 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 expense; or
(3) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience 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.

(c) Nothing in subsection (a)(9) of this section shall apply:

(1) If the insurer has manifested its willingness to renew by issuing or offering to issue a renewal policy, certificate or other evidence of renewal, including the mailing of a renewal premium notice to the insured not less than thirty days in advance of the expiration date of the policy.
(2) If the named insured has demonstrated by some overt action to the insurer or its

agent other than mere nonpayment of premium that he wishes the policy to be cancelled or that he does not wish the policy to be renewed.
(3) To any policy of insurance which has been in effect less than sixty days, including any notice of termination period, unless it is a renewal policy. Any declination of coverage within the sixty-day period provided in this clause shall, for purposes of review by the insurance commissioner, be deemed a refusal to write and shall not be subject to the provisions of subsection (a)(9) of this section.
(4) Any insured may within ten days of the receipt by the insured of notice of cancellation or notice of intention not to renew, request in writing to the insurance commissioner that he review the action of the insurer in cancelling or refusing to renew the policy of such insured.

Section 1171.6. Non-liability for statements or information provided

There shall be no liability on the part of and no cause of action of any nature shall arise against the insurance commissioner, any insurer, the authorized representatives, agents and employees of either, or of any firm, person or corporation furnishing to the insurer information as to reasons for cancellation or refusal to renew for any statement made by them in complying with this act or for providing information pertaining thereto.

Section 1171.7. Power of Commissioner

The Commissioner may examine and investigate the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by this act.

Section 1171.8. Administrative hearing

(a) If, as a result of investigation, the Commissioner has good cause to believe that any person is violating any provision of this act, the Commissioner shall send notice of the violation by certified mail to the person believed to be in violation. The notice shall state the time and place for hearing which shall not be less than thirty days from the date of such notice.

(b) At the time and place fixed for the hearing in the notice, the person shall have an opportunity to be heard and to show cause why an order should not be made by the commissioner to cease and desist from acts constituting a violation of this act and why administrative penalties should not be assessed.

(c) Upon good cause shown, the Commissioner shall permit any person to intervene, appear and be heard at the hearing, either in person or by counsel.

(d) The Commissioner may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence and subpoena witnesses, compel their

attendance and require the production of books, papers, records or other documents which he deems relevant to the hearing. The Commissioner shall cause a record of all evidence and all proceedings at the hearing to be kept.

(e) Following the hearing, the Commissioner shall issue a written order resolving the factual issues presented at the hearing and stating what remedial action, if any, is required of the person charged. The Commissioner shall send a copy of the order to those persons participating in the hearing.

Section 1171.9. Administrative penalty

Upon a determination by hearing that this act has been violated, the Commissioner may issue an order requiring the person to cease and desist from engaging in such violation or, if such violation is a method of competition, act or practice defined in section 5 of this act, the Commissioner may suspend or revoke the person's license.

Section 1171.10. Injunction

If the alleged violator fails to comply with an order of the Commissioner following hearing to cease and desist from unfair methods of competition or an unfair or deceptive act or practice, the Commissioner may cause an action for injunction to be filed in the Commonwealth Court or the Court of Common Pleas of the county in which the violation occurred.

Section 1171.11. Civil penalties

In addition to any penalties imposed pursuant to this act, the court may, in an action filed by the Commissioner, impose the following civil penalties:

(1) For each method of competition, act or practice defined in section 5 of this act and in violation of this act which the person knew or reasonably should have known was such a violation, a penalty of not more than five thousand dollars ($5,000) for each violation but not to exceed and aggregate penalty of fifty thousand dollars ($50,000) in any six month period;

(2) For each method of competition, act or practice defined in section 5 of this act and in violation of this act which the person did not know nor reasonably should have known was such a violation, a penalty of not more than one thousand dollars ($1,000) for each violation but not to exceed an aggregate penalty of ten thousand dollars ($10,000) in any six month period; and

(3) For each violation of an order issued by the Commissioner pursuant to section 9 of this act, while such order is in effect, a penalty of not more than ten thousand dollars ($10,000).

Section 1171.12. Repealed. 1978, April 28, P.L. 202, No. 53, § 2(a)[1466], effective

June 27, 1978

Section 1171.13. Provisions of act additional to existing law

The powers vested in the Commissioner by this act are additional to any other powers to enforce any penalties, fines or forfeitures authorized by law with respect to the methods, acts and practices declared to be unfair and deceptive.

Section 1171.14. Exclusions

Health care plans administered by Joint Boards of Trustees pursuant to section 302 of The Labor Management Relations Act, 29 U.S.C. § 141, et seq., and employer administered health care plans pursuant to collective bargaining agreements which pay benefits from the assets of the trust or the funds of the employer as opposed to payments through an insurance company shall not be subject to any of the provisions of this act.