CHAPTER 23

TRADE PRACTICES AND FRAUDS

§2151. Purpose

The purpose of this chapter 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, by defining or providing for the determination of all such practices in other states by residents of 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. [PL 1985, c. 648, §4 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1985, c. 648, §4 (AMD).

§2151-A. Hearings

All hearings held under this chapter shall be in accordance with the procedures set forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV. [PL 1977, c. 694, §414 (NEW).]

SECTION HISTORY

PL 1977, c. 694, §414 (NEW).

§2151-B. Rules

Subject to the applicable requirements and procedures of the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, the superintendent may promulgate rules defining, limiting or prescribing acts and practices which are deemed to be in violation of this chapter. [PL 1985, c. 648, §5 (NEW).]

SECTION HISTORY

PL 1985, c. 648, §5 (NEW).

§2152. Unfair methods; deceptive acts prohibited

No person shall engage in this State in any trade practice which is defined in this chapter, as, or determined pursuant to this chapter, to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance. No resident of this State shall engage in any other state in any trade practice which is defined in this chapter as, or determined pursuant to this chapter to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2152-A. Life insurance solicitation

It shall be an unfair practice under this chapter for any insurer, agent or broker to solicit, negotiate or procure the purchase of life insurance within this State, except in compliance with life insurance cost disclosure rules which shall be adopted in accordance with the Maine Administrative Procedure Act Title 5, chapter 375, by the superintendent by July 1, 1980. [PL 1979, c. 447 (NEW).]

SECTION HISTORY

PL 1979, c. 447 (NEW).

§2152-B. Unfair solicitation methods

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Cold lead advertising" means making use directly or indirectly of a method of marketing that fails to disclose in a conspicuous manner that a purpose of the marketing is insurance sales solicitation and that contact will be made by an insurance producer or insurance company. [PL 2007, c. 53, §1 (NEW).]

B. "Medicare products" includes Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D, Medicare Advantage and Medicare supplement plans. [PL 2007, c. 53, §1 (NEW).]
[PL 2007, c. 53, §1 (NEW).]

2. Unfair solicitation methods. It is an unfair trade practice under this chapter for an insurer or producer to:

A. Sell, solicit or negotiate the purchase of health insurance in this State through the use of cold lead advertising; [PL 2007, c. 53, §1 (NEW).]

B. Use an appointment that was made to discuss Medicare products or to solicit the sale of Medicare products in order to solicit sales of life insurance, health insurance or annuity products unless the consumer requests such solicitation and the products to be discussed are clearly identified to the consumer in writing at least 48 hours in advance of the appointment; [PL 2023, c. 243, §2 (AMD).]

C. Solicit the sale of Medicare products door-to-door prior to receiving an invitation from a consumer; and [PL 2023, c. 243, §2 (AMD).]

D. Use an advertisement, solicitation, informational brochure, mailer or other promotional material using the terms "Medicare," "Medicaid" or "MaineCare" that mimics or implies that it is an official document from a state or federal agency. [PL 2023, c. 243, §2 (NEW).]
[PL 2023, c. 243, §2 (AMD).]

SECTION HISTORY

PL 2007, c. 53, §1 (NEW). PL 2023, c. 243, §2 (AMD).

§2152-C. Disclosures in printed marketing materials of Medicare products

1. Disclosures. Except as provided in subsections 2 and 3, a person may not use printed materials marketing Medicare products unless the material:

A. Includes a statement printed on the top and both the front and back of the material in type size no smaller than the largest type size on the material stating "This is an advertisement and solicitation"; [PL 2023, c. 243, §3 (NEW).]

B. Contains in a type size no smaller than the 2nd largest type size on the material stating "[Name of person sponsoring the promotional material] is a private company that is not Medicare, Medicaid or MaineCare and is not a governmental agency"; [PL 2023, c. 243, §3 (NEW).]

C. Contains in a type size no smaller than the 2nd largest type size on the material any other disclaimer on the material; and [PL 2023, c. 243, §3 (NEW).]

D. Does not use a type color for the disclaimer required in paragraph A that is in grayscale or other faded tone, or a font that does not mimic or is not similar to a font used in an official document from a state or federal agency. [PL 2023, c. 243, §3 (NEW).]
[PL 2023, c. 243, §3 (NEW).]

2. No disclosure required. The requirements of subsection 1 do not apply to:

A. Informational brochures or other material developed or distributed by a state or federal regulatory agency or a nonprofit organization; or [PL 2023, c. 243, §3 (NEW).]

B. Information related to an existing policy, from a policyholder's insurer, licensed agent or agency of record, including, but not limited to, information for the purpose of assisting, educating or communicating the status of plan benefits, claims, appeals, grievances or notice of termination. [PL 2023, c. 243, §3 (NEW).]

[PL 2023, c. 243, §3 (NEW).]

3. Application. This subsection does not apply to any marketing material that has been filed with and approved by the superintendent, or filed with and approved by the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services or filed with the Centers for Medicare and Medicaid Services under that agency's policies allowing for the filing and use of certain marketing materials. Evidence of that approval or filing with the Centers for Medicare and Medicaid Services must be produced upon request of the superintendent.
[PL 2023, c. 243, §3 (NEW).]

4. Rules. The superintendent may adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2023, c. 243, §3 (NEW).]

SECTION HISTORY

PL 2023, c. 243, §3 (NEW).

§2153. Misrepresentation; false advertising of policies

No person shall make, issue, circulate, or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or make any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or make any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or use any name or title on any policy or class of policies misrepresenting the true nature thereof. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2154. False information; advertising

A person may not make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication or on a business card, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio 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 that person's insurance business or with respect to the name of a financial institution in a manner that is untrue, deceptive or misleading. [PL 2007, c. 118, §1 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 2005, c. 46, §1 (AMD). PL 2007, c. 32, §1 (AMD). PL 2007, c. 118, §1 (AMD).

§2155. "Twisting" prohibited

No person shall make or issue, or cause to be made or issued, any written or oral statement misrepresenting or making incomplete comparisons as to the terms, conditions, or benefits contained

in any policy for the purpose of inducing or attempting or tending to induce the policyholder to lapse, forfeit, borrow against, surrender, retain, exchange, modify, convert, or otherwise affect or dispose of any insurance policy. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2155-A. Dumping prohibited

The guaranteed issue requirements of section 2736-C may not be used by insurers, health maintenance organizations, agents, brokers, consultants or any other persons to provide separate coverage to an employee or dependent with a health condition to improve the claims experience of an employer-sponsored group health benefit plan. [PL 1997, c. 370, Pt. B, §1 (NEW).]

SECTION HISTORY

PL 1997, c. 370, §B1 (NEW).

§2156. False or misleading financial statements

1. No person shall file with any supervisory or other public official, or make, publish, disseminate, circulate or deliver to any person, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive.
[PL 1969, c. 132, §1 (NEW).]

2. No person shall make any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omit to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.
[PL 1969, c. 132, §1 (NEW).]

3. No person shall advertise the capital or assets of an insurer without in the same advertisement setting forth the amount of the insurer's liabilities.
[PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2157. Defamation

No person shall make, publish, disseminate, or circulate, directly or indirectly, or aid, abet or encourage 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 an insurer, or of an organization proposing to become an insurer, and which is calculated to injure any person engaged or proposing to engage in the business of insurance. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2158. Boycott, coercion and intimidation

No person shall: [PL 1969, c. 132, §1 (NEW).]

1. Enter into any agreement to commit, or by any concerted action commit, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of or monopoly in the business of insurance.

[PL 1969, c. 132, §1 (NEW).]

2. Enter into any agreement to commit any act of boycott, coercion or intimidation, or in pursuance thereof monopolize or attempt to monopolize any part of the business of insurance.
[PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2159. Unfair discrimination -- life insurance, annuities and health insurance

1. No person shall make or permit 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.
[PL 1969, c. 132, §1 (NEW).]

2. No person may make or permit 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 health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. Nothing in this provision prohibits an insurer from providing incentives for insureds to use the services of a particular provider.
[PL 1985, c. 704, §3 (AMD).]

3. It shall be an unfair trade practice in the business of insurance for any insurer to discriminate unfairly against any person who has tested positive for the presence of the human immunodeficiency antigen or the presence of an antibody to the human immunodeficiency virus or who has Acquired Immune Deficiency Syndrome or AIDS, AIDS Related Complex (ARC) or HIV related diseases provided that nothing in this subsection prohibits an insurer from treating individuals of different classes and of unequal expectations of life, or essentially different hazards, differently in accordance with subsection 1 or 2.
[PL 1989, c. 176, §2 (NEW).]

4. It shall not be unfair discrimination for group life insurance policies or contracts subject to chapter 31 to contain an exclusion or restriction for death caused by Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV related diseases which existed 6 months prior to the individual's effective date of insurance if an actuarial justification is filed and approved by the superintendent. The exclusion or restriction may run for no longer than the incontestable period of the policy within the meaning of section 2615.
[PL 1989, c. 176, §2 (NEW).]

5. Definitions. As used in this section, "HIV" and "antibody to HIV" have the same meanings as set out in Title 5, section 19201.
[PL 1991, c. 3, §3 (NEW).]

6. Test results. No insurer may request any person to reveal whether the person has obtained a test for the presence of antibodies to HIV or a test to measure the virus or to reveal the results of such tests taken prior to an application for insurance coverage.
[PL 1991, c. 3, §3 (NEW).]

7. Discrimination prohibited; preexposure prophylaxis medication to prevent HIV infection. Notwithstanding any provision of law to the contrary, an insurer authorized to do business in this State may not:

A. Limit coverage or refuse to issue or renew coverage of an individual under a life, disability income or long-term care insurance policy due to the fact that the individual has been prescribed preexposure prophylaxis medication to prevent HIV infection; [PL 2019, c. 596, §1 (NEW).]

B. Consider the fact that an individual has been issued a prescription for preexposure prophylaxis medication to prevent HIV infection in determining the premium rate for coverage of that individual under a life, disability income or long-term care insurance policy; or [PL 2019, c. 596, §1 (NEW).]

C. Otherwise discriminate in the offering, issuance, cancellation, amount of coverage, price or any other condition of a life, disability income or long-term care insurance policy based solely and without any additional actuarial justification upon the fact that an individual has been issued a prescription for preexposure prophylaxis medication to prevent HIV infection. [PL 2019, c. 596, §1 (NEW).]

[PL 2019, c. 596, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1985, c. 704, §3 (AMD). PL 1989, c. 176, §2 (AMD). PL 1991, c. 3, §3 (AMD). PL 2019, c. 596, §1 (AMD).

§2159-A. Insurance discrimination solely on account of physical or mental disability prohibited

No insurer authorized to transact business in this State may refuse to insure or continue to insure, limit the amount, extent or kind of coverage available to an individual or charge an individual a rate different from that normally charged for the same coverage solely because the insured or the applicant for insurance is blind or partially blind. [PL 1985, c. 445 (RPR).]

An insurer authorized to transact business in this State may not refuse to insure or continue to insure, limit the amount, extent or kind of coverage available to an individual or charge an individual a rate different from that normally charged for the same coverage solely because the insured or the applicant for insurance has a physical or mental disability, as defined in Title 5, section 4553, subsection 7-A, other than blindness or partial blindness, unless the basis for that action is clearly demonstrated through sound actuarial evidence. [PL 2021, c. 348, §36 (AMD).]

1. Deaf.
[PL 1985, c. 445 (RP).]

2. Developmentally disabled.
[PL 1985, c. 445 (RP).]

SECTION HISTORY

PL 1975, c. 255 (NEW). PL 1975, c. 675 (AMD). PL 1977, c. 279 (RPR). PL 1979, c. 127, §156 (AMD). PL 1979, c. 663, §142 (AMD). PL 1985, c. 445 (RPR). PL 2021, c. 348, §36 (AMD). PL 2025, c. 348, §28 (AMD).

§2159-B. Discrimination against victims of domestic abuse prohibited

1. Discrimination prohibited. An insurer, nonprofit hospital and medical service organization or health maintenance organization that issues life, health or disability coverage may not deny, cancel, refuse to renew or restrict coverage of any person or require the payment of additional charges based on the fact or perception that the person is, or may become, the victim of domestic abuse, under Title 19-A, section 4102. This subsection does not prohibit applying an underwriting or rating criterion to a victim of domestic abuse based on physical or mental history or other factors of general applicability regardless of the underlying cause and in accordance with the requirements of section 2159, subsections 1 and 2. An insurer, nonprofit hospital and medical service organization or health maintenance organization may not be held criminally or civilly liable for any cause of action that may result from compliance with this subsection. This subsection does not prohibit an insurer, nonprofit hospital and medical service organization or health maintenance organization from declining to issue coverage to an applicant known to be, or to have been, an abuser of the proposed insured.
[PL 2021, c. 647, Pt. B, §52 (AMD); PL 2021, c. 647, Pt. B, §65 (AFF).]

2. Justification of adverse insurance decisions. An insurer, nonprofit hospital and medical service organization or health maintenance organization that issues life, health or disability coverage that takes an action that adversely affects an applicant or insured on the basis of a medical condition that the insurer, nonprofit hospital and medical service organization or health maintenance organization knows or has reason to know is related to domestic abuse shall explain the reasons for its action to the applicant or insured in writing and shall demonstrate that its action, and any applicable policy provision:

A. Does not have the purpose or effect of treating abuse status as a medical condition or underwriting or rating criterion; [PL 2001, c. 16, §1 (NEW).]

B. Is not based upon any actual or perceived correlation between a medical condition and domestic abuse; [PL 2001, c. 16, §1 (NEW).]

C. Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition or disability without regard to whether the medical condition or disability is related to domestic abuse; and [PL 2001, c. 16, §1 (NEW).]

D. Except for claims actions, is based on a determination made in conformance with sound actuarial principles and otherwise supported by actual or reasonably anticipated experience that there is a correlation between the medical condition or disability and a material increase in insurance risk. [PL 2001, c. 16, §1 (NEW).]

[PL 2001, c. 16, §1 (NEW).]

SECTION HISTORY

PL 1995, c. 553, §1 (NEW). RR 1997, c. 2, §50 (COR). PL 2001, c. 16, §1 (RPR). PL 2021, c. 647, Pt. B, §52 (AMD). PL 2021, c. 647, Pt. B, §65 (AFF).

§2159-C. Discrimination on the basis of genetic information or testing

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Genetic characteristic" means any inherited gene or chromosome, or alteration of a gene or chromosome, that is scientifically or medically believed to predispose an individual to a disease, disorder or syndrome or to be associated with a statistically significant increased risk of development of a disease, disorder or syndrome. [PL 1997, c. 677, §2 (NEW).]

B. "Genetic information" means the information concerning genes, gene products or inherited characteristics that may be obtained from an individual or family member. [PL 1997, c. 677, §2 (NEW).]

C. "Genetic test" means a test for determining the presence or absence of an inherited genetic characteristic in an individual, including tests of nucleic acids, such as deoxyribonucleic acid, or DNA, ribonucleic acid, or RNA, or mitochondrial DNA, and tests of chromosomes or proteins in order to identify a predisposing genetic characteristic. [PL 1997, c. 677, §2 (NEW).]

D. "Carrier" means an insurer, nonprofit hospital and medical service organization or health maintenance organization. [PL 2009, c. 244, Pt. D, §1 (NEW).]

[PL 2009, c. 244, Pt. D, §1 (AMD).]

2. Discrimination in health, hospital and dental insurance. A carrier that issues individual or group hospital, health or dental insurance is subject to the requirements of this subsection. This subsection does not apply to accidental injury, specified disease, hospital indemnity, disability, long-term care and other limited benefit health insurance policies and contracts.

A. A carrier may not discriminate against an individual or eligible dependent on the basis of genetic information or the refusal to submit to a genetic test or make available the results of a genetic test or on the basis that the individual or eligible dependent received a genetic test or genetic counseling

in the issuance, withholding, extension or renewal of any hospital confinement or other health insurance, as defined by the superintendent, by rule, or in the fixing of the rates, terms or conditions for insurance, or in the issuance or acceptance of any application for insurance. [PL 2009, c. 244, Pt. D, §2 (NEW).]

B. Except as provided in this paragraph, a carrier may not request or require an individual to undergo a genetic test.

(1) Nothing in this subsection limits the authority of a health care professional who is providing health care services to an individual to request that that individual undergo a genetic test.

(2) A carrier may request, but not require, that an individual undergo a genetic test if the conditions described in this subparagraph are met:

(a) The request is made pursuant to research that complies with 45 Code of Federal Regulations, Part 46 or equivalent federal regulations and any applicable state or local laws, rules or regulations for the protection of human subjects in research;

(b) The carrier clearly indicates to the individual to whom the request is made, or in the case of a minor child to the legal guardian of the individual, that compliance with the request is voluntary and noncompliance will have no effect on enrollment status or premium or contribution amounts;

(c) Genetic information collected or acquired under this subparagraph is not used for purposes of determining eligibility for benefits, computing premium or contribution amounts, applying any preexisting condition exclusion or any other activities related to the creation, renewal or replacement of a health insurance contract; and

(d) The carrier complies with all applicable federal laws and regulations. [PL 2009, c. 244, Pt. D, §2 (NEW).]

C. A carrier may not request, require or purchase genetic information for purposes of determining eligibility for benefits, computing premium or contribution amounts, applying any preexisting condition exclusion or any other activities related to the creation, renewal or replacement of a health insurance contract. [PL 2009, c. 244, Pt. D, §2 (NEW).]

D. A carrier may not request, require or purchase genetic information with respect to an individual prior to the individual's enrollment under the plan or coverage in connection with the enrollment. [PL 2009, c. 244, Pt. D, §2 (NEW).]

E. If a carrier obtains genetic information incidental to the requesting, requiring or purchasing of other information concerning an individual, the request, requirement or purchase is not considered a violation of paragraph D if the request, requirement or purchase is not in violation of paragraph C. [PL 2009, c. 244, Pt. D, §2 (NEW).]

F. A reference in this subsection to genetic information concerning an individual includes:

(1) With respect to an individual who is a pregnant woman, genetic information of any fetus carried by that individual; and

(2) With respect to an individual using an assisted reproductive technology, genetic information of any embryo legally held by the individual. [PL 2009, c. 244, Pt. D, §2 (NEW).]

[PL 2009, c. 244, Pt. D, §2 (RPR).]

3. Discrimination in life, disability and long-term care insurance. An insurer may not make or permit any unfair discrimination against an individual in the application of genetic information or the results of a genetic test in the issuance, withholding, extension or renewal of an insurance policy for life, credit life, disability, long-term care, accidental injury, specified disease, hospital indemnity or

credit accident insurance or an annuity. For the purposes of this subsection, "unfair discrimination" includes, but is not limited to, the application of the results of a genetic test in a manner that is not reasonably related to anticipated claims experience.

A. If the superintendent has reason to believe that unfair discrimination has occurred and that a proceeding by the superintendent is in the interest of the public, the superintendent, in accordance with chapter 3, shall serve upon the insurer a statement of the charges. Upon a determination that the practice or act of the insurer is in conflict with this subsection, the superintendent shall issue an order requiring the insurer to cease and desist from engaging in the practice or act and may order payment of a penalty consistent with the provisions of section 12-A. [PL 1997, c. 677, §2 (NEW).]

B. If, in the issuance, withholding, extension or renewal of an insurance policy covered by this subsection, an insurer uses the results of a genetic test in compliance with this subsection, the insurer shall notify the individual who is the subject of the genetic test that such a test is required and shall obtain the individual's authorization in accordance with the requirements of chapter 24. If a genetic test is required, the insurer shall ensure that the individual states in writing whether the individual wishes to be informed of the test results and, if authorized by the individual, shall provide a copy of the test results, along with a written interpretation of the results by a qualified professional, to the individual or to a physician or other health care practitioner designated by the individual. [PL 1997, c. 677, §2 (NEW).]

[PL 1997, c. 677, §2 (NEW).]

4. Use of information obtained through direct-to-consumer genetic testing. In connection with the issuance, withholding, extension or renewal of an insurance policy for life, credit life, disability, long-term care, accidental injury, specified disease, hospital indemnity or credit accident insurance or an annuity, an insurer may not request, require, purchase or use information obtained from an entity providing direct-to-consumer genetic testing without the informed written consent of the individual who has been tested.

[PL 2019, c. 208, §1 (NEW).]

SECTION HISTORY

PL 1997, c. 677, §2 (NEW). PL 2009, c. 244, Pt. D, §§1, 2 (AMD). PL 2019, c. 208, §1 (AMD).

§2159-D. Discrimination against live organ donation prohibited in life insurance, disability insurance and long-term care insurance

1. Living organ donor. For the purposes of this section, "living organ donor" means an individual who is not deceased who donates all or part of an organ from that individual.

[PL 2017, c. 20, §1 (NEW).]

2. Discrimination prohibited. Notwithstanding any other provision of law, an insurer authorized to do business in this State may not:

A. Limit coverage or refuse to issue or renew coverage of an individual under any life insurance, disability insurance or long-term care insurance policy due to the status of that individual as a living organ donor; [PL 2017, c. 20, §1 (NEW).]

B. Preclude an individual from donating all or part of an organ as a condition of receiving coverage under a life insurance, disability insurance or long-term care insurance policy; [PL 2017, c. 20, §1 (NEW).]

C. Consider the status of an individual as a living organ donor in determining the premium rate for coverage of that individual under a life insurance, disability insurance or long-term care insurance policy; or [PL 2017, c. 20, §1 (NEW).]

D. Otherwise discriminate in the offering, issuance, cancellation, amount of coverage, price or any other condition of a life insurance, disability insurance or long-term care insurance policy based solely and without any additional actuarial justification upon the status of an individual as a living organ donor. [PL 2017, c. 20, §1 (NEW).]

[PL 2017, c. 20, §1 (NEW).]

SECTION HISTORY

PL 2017, c. 20, §1 (NEW).

§2159-E. Discrimination against naloxone hydrochloride or another opioid overdose-reversing medication purchases prohibited in life insurance

1. Discrimination prohibited. Notwithstanding any provision of law to the contrary and except as provided in subsection 2, an insurer authorized to do business in this State may not:

A. Limit coverage or refuse to issue or renew coverage of an individual under any life insurance policy due to the fact that the individual has been issued a prescription for naloxone hydrochloride or another opioid overdose-reversing medication or has purchased naloxone hydrochloride or another opioid overdose-reversing medication in accordance with Title 22, section 2353; [PL 2023, c. 161, §4 (AMD).]

B. Consider the fact that an individual has been issued a prescription for naloxone hydrochloride or another opioid overdose-reversing medication or has purchased naloxone hydrochloride or another opioid overdose-reversing medication in determining the premium rate for coverage of that individual under a life insurance policy; or [PL 2023, c. 161, §4 (AMD).]

C. Otherwise discriminate in the offering, issuance, cancellation, amount of coverage, price or any other condition of a life insurance policy based solely and without any additional actuarial justification upon the fact that an individual has been issued a prescription for naloxone hydrochloride or another opioid overdose-reversing medication or has purchased naloxone hydrochloride or another opioid overdose-reversing medication. [PL 2023, c. 161, §4 (AMD).]

An opioid overdose-reversing medication referenced in this subsection must be approved by the federal Food and Drug Administration.

[PL 2023, c. 161, §4 (AMD).]

2. Exception. An insurer may take an action described in subsection 1 with respect to an individual who has a demonstrated history of opioid use disorder.

[PL 2019, c. 203, §1 (NEW).]

SECTION HISTORY

PL 2019, c. 203, §1 (NEW). PL 2023, c. 161, §4 (AMD).

§2159-F. Discrimination in medical malpractice insurance based solely on legally protected health care activity

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Adverse action" means revocation, suspension or other disciplinary action against a health care professional's license. [PL 2023, c. 345, §1 (NEW).]

B. [PL 2023, c. 648, Pt. E, §3 (RP).]

C. "Aid and assist legally protected health care activity" and "aiding and assisting legally protected health care activity" have the same meanings as in Title 14, section 9002, subsection 1. [PL 2023, c. 648, Pt. E, §3 (NEW).]

D. "Legally protected health care activity" has the same meaning as in Title 14, section 9002, subsection 8. [PL 2023, c. 648, Pt. E, §3 (NEW).]

[PL 2023, c. 648, Pt. E, §3 (AMD).]

2. Discrimination prohibited. An insurer that provides medical malpractice insurance in this State may not refuse to issue or renew coverage, cancel or restrict coverage, impose any sanctions, fines, penalties or rate increases or require the payment of additional charges by a health care professional who engages in legally protected health care activity or aids and assists legally protected health care activity on the sole basis that the health care professional is acting in violation of another state's law related to legally protected health care activity or aiding and assisting legally protected health care activity or is subject to an adverse action against the health care professional's license in another state for a violation of that state's law related to legally protected health care activity or aiding and assisting legally protected health care activity.

[PL 2023, c. 648, Pt. E, §3 (AMD).]

3. Action based on adverse action in another state prohibited. An insurer that provides medical malpractice insurance in this State may not refuse to issue or renew coverage, cancel or restrict coverage or require the payment of additional charges by a health care professional who engages in legally protected health care activity or aids and assists legally protected health care activity as a result of an adverse action against the health care professional's license in another state if the adverse action is solely based on a violation of the other state's law related to legally protected health care activity or aiding and assisting legally protected health care activity.

[PL 2023, c. 648, Pt. E, §3 (AMD).]

SECTION HISTORY

PL 2023, c. 345, §1 (NEW). PL 2023, c. 648, Pt. E, §3 (AMD).

§2160. Rebates -- life, health and annuity contracts

1. Limitation. Except as otherwise provided by law, no person may:

A. Knowingly permit or offer to make or make any contract of life insurance, life annuity or health insurance or agreement concerning that contract that is not plainly expressed in the contract issued; [PL 1997, c. 457, §38 (NEW).]

B. Pay or allow or give or offer to pay, allow or give directly or indirectly as inducement to life or health insurance or life annuity:

(1) Any rebate of premiums payable on the contract;

(2) Any special favor or advantage in the dividends or other benefits;

(3) Any paid employment or contract for services of any kind; or

(4) Any valuable consideration or inducements not specified in the contract; or [PL 1997, c. 457, §38 (NEW).]

C. Directly or indirectly give or sell or purchase or offer or agree to give, sell, purchase or allow as inducement to life or health insurance or life annuity or in connection with the insurance or annuity or any agreement, whether or not specified in the policy or contract, of any form or nature promising:

(1) Returns or profits;

(2) Any stocks, bonds or other securities;

(3) Interest present in or contingent on or measured by the agreement of any insurer or other corporation, association or partnership; or

(4) Any dividends or profits accrued or to accrue on an agreement. [PL 1997, c. 457, §38 (NEW).]

[PL 1997, c. 457, §38 (NEW).]

2. Benefit not associated with indemnification or loss. Unless otherwise provided by law, a provision may not be included within an insurance policy if the sole intent of the provision is to give to the insured a benefit that is not associated with indemnification or loss. This subsection does not apply to annuities.

[PL 1997, c. 592, §66 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1997, c. 457, §38 (RPR). PL 1997, c. 592, §66 (AMD).

§2161. Exceptions to discrimination, rebates, stock inducements provision -- life, health and annuity contracts

1. Nothing in sections 2159 and 2160 shall be construed as including within the definition of discrimination or rebates any of the following practices:

A. 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 any such bonuses, or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the insurer and its policyholders; [PL 1969, c. 132, §1 (NEW).]

B. In the case of life insurance policies issued on the 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; [PL 1969, c. 132, §1 (NEW).]

C. 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; [PL 1969, c. 132, §1 (NEW).]

D. Reduction of premium rate for policies of large amount, but not exceeding savings in issuance and administration expenses reasonably attributable to such policies as compared with policies of similar plan issued in smaller amounts; [PL 1969, c. 132, §1 (NEW).]

E. Reduction in premium rates for life or health insurance policies or annuity contracts on salary savings, payroll deduction, preauthorized check, bank draft or similar plans in amounts reasonably commensurate with the savings made by the use of such plans; [PL 1969, c. 132, §1 (NEW).]

F. The issuance of policies of group insurance with or without annuities at rates less than the usual rate of premiums for individual policies or contracts as otherwise provided for by law; [PL 1969, c. 132, §1 (NEW).]

G. Allowance to an agent or broker, and receipt by the agent or broker, of commissions with respect to insurance written on the agent or broker. [RR 2021, c. 1, Pt. B, §205 (COR).]

[RR 2021, c. 1, Pt. B, §205 (COR).]

2. Nothing in this chapter shall be construed as including within the definition of securities as inducements to purchase insurance the selling or offering for sale, contemporaneously with life insurance or annuities, of mutual fund shares or face amount certificates of regulated investment companies under offerings registered with the Securities and Exchange Commission where such shares or such face amount certificates or such insurance or annuities may be purchased independently of and not contingent upon purchase of the other, at the same price and upon the same terms and conditions as where purchased independently.

[PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). RR 2021, c. 1, Pt. B, §205 (COR).

§2162. Unfair discrimination, rebates prohibited -- property, casualty, surety insurance

1. No property, casualty or surety insurer or any employee or representative thereof, and no broker, agent or solicitor as to such insurance shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to insurance, or after insurance has been effected, any rebate, discount, abatement, credit or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement whatever, not specified or provided for in the policy, except to the extent provided for in an applicable filing with the superintendent as provided by law.

A. Unless otherwise provided by law, a provision may not be included within an insurance policy if the sole intent of the provision is to give to the insured a benefit that is not associated with indemnification or loss. [PL 1997, c. 457, §39 (NEW).]

B. Notwithstanding any other provision of law, the superintendent may approve filings allowing reductions in premium associated with savings in issuance and administrative expenses except that, if a filing affecting surety bonds for construction projects financed in whole or in part with public funds allows for any reduction in premium to be given, paid, allowed or offered after execution of the bond, including, without limitation, any rebate, discount, consideration or inducement of any kind, the filing must ensure that the entire amount of the reduction will be paid directly to the governmental department or agency administering the public funds for the project. In the case of a project financed only in part with public funds, the governmental department or agency may be paid a percentage of the reduction equal to the percentage of the project that is financed with public funds. [PL 1997, c. 457, §39 (NEW).]

[PL 1997, c. 457, §39 (AMD).]

2. No such insurer shall make or permit any unfair discrimination between insureds or property having like insuring or risk characteristics in the premium or rates charged for insurance, or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the insurance. [PL 1969, c. 132, §1 (NEW).]

3. Nothing in this section shall be construed as prohibiting the payment of commissions or other compensation to duly licensed agents, brokers or solicitors, or as prohibiting any insurer from allowing or returning to its participating policyholders, members or subscribers, dividends, savings or unabsorbed premium deposits. As used in this section the word "insurance" includes suretyship and the word "policy" includes bond. This section does not apply as to wet marine and transportation insurance. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD). PL 1997, c. 457, §39 (AMD).

§2162-A. Payment of dividend conditioned upon renewal; unfair trade practice

It is an unfair trade practice to make the payment of a policy dividend or any portion of a dividend conditioned upon renewal of the policy or contracts. This section does not apply to the first year dividend on life insurance policies. [PL 1985, c. 548 (NEW).]

SECTION HISTORY

PL 1985, c. 548 (NEW).

§2163. Receipt of rebate, illegal inducement prohibited

1. Limitations. No person may knowingly receive or accept, directly or indirectly:

A. Any rebate of premium or part of a premium; [PL 1997, c. 457, §40 (NEW).]

B. Any producer's commission on a premium or part of a premium payable on any policy of insurance or annuity contract; [PL 1997, c. 457, §40 (NEW).]

C. Any special favor or advantage in the dividend or other benefits to accrue; or [PL 1997, c. 457, §40 (NEW).]

D. Anything of value as inducement to any policy of insurance or annuity contract or in connection with any policy of insurance or annuity contract that is not specified, promised or provided for in the policy or contract, except as otherwise provided by law. [PL 1997, c. 457, §40 (NEW).]

[PL 1997, c. 457, §40 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1997, c. 457, §40 (RPR).

§2163-A. Permitted activities

1. Permissible gifts and prizes. Notwithstanding any other provision in sections 2160 to 2163, an insurer, an employee of an insurer or a producer may offer to give gifts in connection with marketing for the sale or retention of contracts of insurance, as long as the cost does not exceed $100 per year per person, and conduct raffles or drawings, as long as there is no participation cost to entrants and as long as the prizes are not valued in excess of $500. Nothing in sections 2160 to 2163 may be construed to prohibit an insurance producer from receiving a fee rather than commission on the sale of property and casualty insurance in accordance with section 1450 and rules adopted by the superintendent.

Gifts and prizes given pursuant to this section may not be in the form of cash.
[PL 2017, c. 84, §1 (NEW).]

2. Permissible value-added service or activity. An insurer, an employee of an insurer or a producer may offer to provide a value-added service or activity, offered or provided without fee or at a reduced fee, that is related to the coverage provided by an insurance contract if the provision of the value-added service or activity does not violate any other applicable statute or rule and is:

A. Clearly identified and included within the insurance contract; or [PL 2017, c. 84, §1 (NEW).]

B. Directly related to the servicing of the insurance contract or offered or undertaken to provide risk control for the benefit of a client. [PL 2017, c. 84, §1 (NEW).]

[PL 2017, c. 84, §1 (NEW).]

3. Services for free or for less than fair market value. This section does not prohibit a person from offering or providing services, whether or not the services are directly related to an insurance contract, for free or for less than fair market value as long as the receipt of the services is not contingent upon the purchase of insurance and the services are offered on the same terms to all potential insurance customers. A person that offers or provides services under this subsection for free or for less than fair market value shall disclose conspicuously in writing to the recipient before the purchase of insurance, receipt of a quote for insurance or designation of an agent of record that receipt of the services is not contingent on the purchase of insurance.
[PL 2017, c. 84, §1 (NEW).]

4. Rules. The superintendent may adopt rules as necessary to make reasonable modifications to the standards in this section. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2017, c. 84, §1 (NEW).]

SECTION HISTORY

PL 1997, c. 457, §41 (NEW). PL 1999, c. 8, §1 (AMD). PL 2017, c. 84, §1 (RPR).

§2164. Stock operations and advisory board contracts

No person shall issue or deliver or permit its 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. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2164-A. Direct billing, notice

No insurer, domestic or foreign, shall, except upon the written request of the insured, convert or convert upon renewal any contract of property or casualty insurance, excluding accident and health insurance and life insurance, to a direct billing basis until it has given 90 days advance written notice thereof to its resident agents. [PL 1969, c. 548 (NEW).]

SECTION HISTORY

PL 1969, c. 548 (NEW).

§2164-B. Conflicts of interest in appraisals

(REPEALED)

SECTION HISTORY

PL 1979, c. 171 (NEW). PL 1979, c. 471 (NEW). PL 1979, c. 663, §143 (RAL). PL 1995, c. 522, §1 (RP).

§2164-C. Free competition

1. Appraisals or repairs to motor vehicle glass. A domestic or foreign insurer or its agent or employee may not require, directly or indirectly, that appraisals or repairs to motor vehicle glass be made or not be made in a specified place of business.

A domestic or foreign insurer or its agent or employee may not contract with any person to act as its agent for purposes of managing, handling or arranging repair or replacement of motor vehicle glass when that person is compensated by payment of a portion of the difference between the list price of the product or services provided and the amount paid to the person providing repair and replacement service.
[PL 2005, c. 101, §1 (NEW).]

2. Appraisals or repairs to motor vehicles for collision damage. A domestic or foreign insurer or its agent or employee may not require, directly or indirectly, that appraisals or repairs to motor vehicles with collision damage be made or not be made in a specified place of business.

A domestic or foreign insurer or its agent or employee may not contract with any person to act as its agent for purposes of managing, handling or arranging repair or replacement of motor vehicles for collision damage when that person is compensated by payment of a portion of the difference between the list price of the product or services provided and the amount paid to the person providing repair and replacement service.

A domestic or foreign insurer or its agent or employee may not recommend the use of a particular motor vehicle repair service or network of repair services without informing the claimant that the claimant is under no obligation to use the recommended repair service or network of repair services.
[PL 2005, c. 101, §1 (NEW).]

SECTION HISTORY

PL 1979, c. 663, §143 (RAL). PL 1993, c. 203, §1 (AMD). PL 2005, c. 101, §1 (RPR).

§2164-D. Unfair claims practices

1. Definition. As used in this section, "insurer" means any person, reciprocal exchange, Lloyd's insurer, fraternal benefit society and any other legal entity engaged in the business of insurance, including, but not limited to, producers, adjusters and 3rd-party administrators. "Insurer" also means nonprofit hospital or medical service organizations, as described in Title 24, section 2301.

A. [PL 1997, c. 634, Pt. A, §1 (RP).]

B. [PL 1997, c. 634, Pt. A, §1 (RP).]

C. [PL 1997, c. 634, Pt. A, §1 (RP).]

D. [PL 1997, c. 634, Pt. A, §1 (RP).]

E. [PL 1997, c. 634, Pt. A, §1 (RP).]
[PL 1997, c. 634, Pt. A, §1 (RPR).]

2. Prohibited activities. It is an unfair claims practice for any domestic, foreign or alien insurer transacting business in this State to commit any act under subsection 3 if:

A. It is committed in conscious disregard of this section and any rules adopted under this section; or [PL 1997, c. 634, Pt. A, §1 (NEW).]

B. It has been committed with such frequency as to indicate a general business practice to engage in that type of conduct. [PL 1997, c. 634, Pt. A, §1 (NEW).]
[PL 1997, c. 634, Pt. A, §1 (RPR).]

3. Unfair practices. Any of the following acts by an insurer, if committed in violation of subsection 2, constitutes an unfair claims practice:

A. Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions related to coverages at issue; [PL 1997, c. 634, Pt. A, §1 (NEW).]

B. Failing to acknowledge with reasonable promptness pertinent written communications with respect to claims arising under its policies; [PL 1997, c. 634, Pt. A, §1 (NEW).]

C. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies; [PL 1997, c. 634, Pt. A, §1 (NEW).]

D. Failing to develop and maintain documented claim files supporting decisions made regarding liability; [PL 1997, c. 634, Pt. A, §1 (NEW).]

E. Refusing to pay claims without conducting a reasonable investigation; [PL 1997, c. 634, Pt. A, §1 (NEW).]

F. Failing to affirm coverage or deny coverage, reserving any appropriate defenses, within a reasonable time after having completed its investigation related to a claim; [PL 1997, c. 634, Pt. A, §1 (NEW).]

G. Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured; [PL 1997, c. 634, Pt. A, §1 (NEW).]

H. Making claim payments to an insured or beneficiary without indicating the coverage under which each payment is being made; [PL 1997, c. 634, Pt. A, §1 (NEW).]

I. Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss and subsequent verification when subsequent verification would result in duplication of information appearing in the formal proof of loss; [PL 1997, c. 634, Pt. A, §1 (NEW).]

J. Failing, in the case of claims denials or offers of compromise settlement, to promptly provide an accurate written explanation of the basis for those actions; [PL 1997, c. 634, Pt. A, §1 (NEW).]

K. Failing to provide forms, accompanied by reasonable explanations for their use, necessary to present claims within 15 calendar days of such a request. This paragraph does not apply when there is an extraordinary loss or series of losses resulting from a catastrophe as determined by the superintendent; or [PL 1997, c. 634, Pt. A, §1 (NEW).]

L. Failing to adopt and implement reasonable standards to ensure that the repairs of a repairer owned by or required to be used by the insurer are performed in a professional manner. [PL 1997, c. 634, Pt. A, §1 (NEW).]

[PL 1997, c. 634, Pt. A, §1 (NEW).]

4. Compelling insureds to institute suits. It is an unfair claims practice for any domestic, foreign or alien insurer transacting business in this State to compel insureds to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them with such frequency as to indicate a general business practice; except that this provision does not apply when the insurer has a reasonable basis to contest liability or dispute the amount of any damages or the extent of any injuries claimed.
[PL 1997, c. 634, Pt. A, §1 (NEW).]

5. Resolution of claims. It is an unfair claims practice for any domestic, foreign or alien insurer transacting business in this State to fail to deal with insureds in good faith to resolve claims made against policies of insureds without just cause and with such frequency as to indicate a general business practice.
[PL 1997, c. 634, Pt. A, §1 (NEW).]

6. Chapter 56-A. The superintendent shall ensure that the provisions of chapter 56-A and any rules adopted pursuant to that chapter are enforced consistent with this section.
[PL 1997, c. 634, Pt. A, §1 (NEW).]

7. Rules. The superintendent may adopt rules necessary to carry out the provisions of this section. Rules adopted pursuant to this section are major substantive rules as defined in Title 5, chapter 375, subchapter II-A.
[PL 1997, c. 634, Pt. A, §1 (NEW).]

8. Private action. This section may not be construed as abridging an insurer's duty to its insured or altering policy provisions. This section may not be construed to create or imply a private cause of action for violation of this section.
[PL 1997, c. 634, Pt. A, §1 (NEW).]

9. Applicability. This section does not apply to claims involving workers' compensation, medical malpractice, fidelity, suretyship or boiler and machinery insurance.
[PL 1997, c. 634, Pt. A, §1 (NEW).]

SECTION HISTORY

PL 1987, c. 291, §1 (NEW). PL 1997, c. 634, §A1 (RPR).

§2164-E. Disclosure of coverage limits to claimant; penalty

Upon written request by a claimant or the claimant's attorney, an insurer doing business in this State shall provide the claimant or the claimant's attorney with the liability coverage limits of that insurer's insured. The insurer must provide the liability coverage limits within 60 days of receipt of the written request. [PL 2009, c. 189, §1 (NEW).]

An insurer who fails to comply with this section is subject to a penalty of $500, plus reasonable attorney's fees and expenses incurred in obtaining the liability coverage limits. [PL 2009, c. 189, §1 (NEW).]

SECTION HISTORY

PL 2009, c. 189, §1 (NEW).

§2165. Desist orders for prohibited practices

(REPEALED)

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD). PL 1983, c. 394, §3 (AMD). PL 1985, c. 648, §§6,7 (AMD). PL 1991, c. 298, §11 (RP).

§2165-A. Cease and desist orders; actions against defined and undefined unfair and deceptive practices

1. Emergency cease and desist orders issued pursuant to section 12-A, subsection 2-A may not be imposed for violations under this section.
[PL 1991, c. 298, §12 (NEW).]

2. The superintendent may issue a cease and desist order pursuant to section 12-A, subsection 2 if, after a hearing, the superintendent finds that any person in this State has engaged or is engaging in any act or practice defined or prohibited under this chapter or rules adopted pursuant to this chapter or that a resident of this State has so engaged or is so engaging in another state.
[PL 1991, c. 298, §12 (NEW).]

3. The superintendent may issue a cease and desist order pursuant to section 12-A, subsection 2 if, after a hearing, the superintendent finds that any person in the State has engaged or is engaging, or that a resident of the State has engaged or is engaging in another state, in an unfair or deceptive practice not defined in this chapter or in rules adopted pursuant to this chapter. For any undefined practice, the civil penalties set forth in section 12-A, subsection 1 may not be imposed for practice engaged in prior to the issuance and service of a valid cease and desist order.
[PL 1991, c. 298, §12 (NEW).]

SECTION HISTORY

PL 1991, c. 298, §12 (NEW).

§2166. Procedures as to undefined practices

(REPEALED)

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD). PL 1985, c. 648, §8 (AMD). PL 1991, c. 298, §13 (RP).

§2167. Service upon unauthorized insurers

Provisions of this chapter applicable to insurers apply fully to unauthorized insurers. If an action under this chapter is brought against an unauthorized insurer, section 2105 applies to all process, notices and statements of charges. [PL 1991, c. 298, §14 (NEW).]

1.
[PL 1991, c. 298, §14 (RP).]

2.
[PL 1991, c. 298, §14 (RP).]

3.
[PL 1991, c. 298, §14 (RP).]

4.
[PL 1991, c. 298, §14 (RP).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD). PL 1991, c. 298, §14 (RPR).

§2167-A. Notice to domiciliary supervisory official

Whenever the superintendent has reason to believe that a foreign or alien insurer or licensed insurance professional is acting in violation of this chapter or chapter 21, the superintendent shall notify the insurance supervisory official of that person's domiciliary jurisdiction. [PL 1991, c. 298, §15 (NEW).]

SECTION HISTORY

PL 1991, c. 298, §15 (NEW).

§2168. Coercion in requiring insurance

1. Prohibition against certain requirements. A person engaged in the business of financing the purchase of real or personal property or of lending money on the security of real or personal property may not require, as a condition to the financing or lending, or as a condition to the renewal or extension of any such loan or to the performance of any other act in connection with the financing or lending, that the purchaser or borrower, or the successors of the purchaser or borrower negotiate through a particular insurer or insurers, insurance agent or agents, broker or brokers, type of insurer or types of insurers, any policy of insurance or renewal thereof issued in connection with the extension of credit. For purposes of this section, the term "policy" includes, but is not limited to, any temporary contract or binder, by whatever name known, under the terms of which insurance coverage commences at a specified time, and continues until a finished policy is issued or the risk is declined and coverage is terminated.
[PL 1997, c. 315, §21 (AMD).]

1-A. Prohibition against unreasonable burdens. A creditor or lender may not, in connection with the extension of credit, interfere with the free choice of a borrower or purchaser under subsection 1 by imposing any unreasonable time or burden on an insurance agent or broker not affiliated with the lender or creditor that is not also imposed on an insurance agent or broker who is affiliated with the lender or creditor. "Affiliate" has the same meaning as set forth in section 1443-A, subsection 1, paragraph A with respect to financial institutions and credit unions and in Title 9-A, section 4-403, with respect to supervised lenders.
[PL 1999, c. 127, Pt. A, §39 (AMD).]

2. Approval of insurer; written criteria. This section does not prevent the exercise by any lender or creditor of its right to approve the insurer selected by the borrower on a reasonable nondiscriminatory basis related to the solvency and assessment policies of the insurer and its ability to service the policy. A lender or creditor who exercises its rights under this subsection shall establish written criteria for approving the insurer selected by the borrower and in the event the creditor or lender actually denies an insurer under that criteria the lender or creditor must provide verbal notice to the customer within 3 business days and written notice within 10 business days. Upon request by a licensed insurer, agent, broker or consultant, a customer, a lender or creditor must within 10 business days of receiving the request provide a copy of its written criteria for approving an insurer.
[PL 1997, c. 315, §23 (AMD).]

2-B. Change of insurance carrier. A purchaser or borrower may change insurance carriers in connection with the extension of credit by a lender or creditor if the change does not violate a condition of the extension of credit regarding adequacy of coverage or other proper basis under subsection 2 or is otherwise prohibited by law.
[PL 1997, c. 315, §24 (NEW).]

3. Violation. A person who violates this section commits a civil violation and is subject to civil penalties and other remedies as provided in section 12-A. The Superior Court, on complaint by any person that this section is being violated, may issue an injunction against the violation and may hold in contempt and punish therefor in case of disregard of the injunction.
[PL 2001, c. 421, Pt. B, §90 (AMD); PL 2001, c. 421, Pt. C, §1 (AFF).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD). PL 1983, c. 394, §4 (AMD). PL 1997, c. 315, §§21-24 (AMD). PL 1999, c. 127, §A39 (AMD). PL 2001, c. 421, §B90 (AMD). PL 2001, c. 421, §C1 (AFF).

§2168-A. Tie-in sales of insurance

1. Definition. As used in this section, "tie-in sales" means the practice of tying the sale of one product to another.
[PL 1991, c. 49 (NEW).]

2. Prohibited tie-in sales. In the purchase of insurance, tie-in sales are an unfair trade practice when:

A. The consumer is required to place additional coverage with an insurer not of the consumer's choice in order to obtain a desired coverage; and [PL 1991, c. 49 (NEW).]

B. The consumer's alternative opportunities to purchase the desired coverage are severely limited or nonexistent. [PL 1991, c. 49 (NEW).]
[PL 1991, c. 49 (NEW).]

3. Penalties. An insurance contract sold in violation of the provisions of this section is voidable at the option of the consumer. Violations of this section are enforceable through section 12-A.
[PL 1991, c. 49 (NEW).]

SECTION HISTORY

PL 1991, c. 49 (NEW).

§2168-B. Solicitation or negotiation involving purchasers or borrowers

A licensed agent or broker affiliated with a lender or creditor may not solicit an application for an insurance contract in connection with the extension of credit or negotiate such a contract from a purchaser or borrower whom the agent or broker knows, or should have known, has applied to receive an extension of credit from that lender or creditor until such time as the creditor or lender has provided by hand or sent written notice to the purchaser or borrower of its action on the application or has documented in writing in the lender's or creditor's records its action on the application. This section does not limit the ability of a lender or creditor to do any of the following: [PL 1997, c. 315, §25 (NEW).]

1. Marketing activities. To engage at any time in marketing activities and solicitations for the sale of insurance, including through the mail or by telephone, that are not specifically directed toward purchasers or borrowers who have applied to receive an extension of credit.
[PL 1997, c. 315, §25 (NEW).]

This section does not apply to group health and group life insurance to the extent authorized by chapters 31 and 35 when the insured is enrolled in the insurance policy, credit life and credit health insurance to the extent authorized by chapter 37, credit property insurance, credit involuntary unemployment insurance, forced placed property insurance, a vendor's single interest policy or any other insurance product as determined by the superintendent. [PL 1997, c. 315, §25 (NEW).]

"Affiliate" has the same meaning as set forth in section 1443-A, subsection 1, paragraph A with respect to financial institutions and credit unions and in Title 9-A, section 4-403 with respect to supervised lenders. [PL 1999, c. 127, Pt. A, §40 (AMD).]

SECTION HISTORY

PL 1997, c. 315, §25 (NEW). PL 1999, c. 127, §A40 (AMD).

§2169. Notice of free choice of agent or insurer

The creditor or lender at the time of application for the loan or at the outset of negotiations regarding the loan or sale shall inform the purchaser or borrower of that person's right of free choice in the selection of the agent and insurer through or by which the insurance in connection with the loan is to be placed, including the right to choose an agent or broker whether or not that agent or broker is affiliated with a creditor or lender. For purposes of this section, "affiliated" has the same meaning as set forth in section 1443-A, subsection 1, paragraph A, with respect to financial institutions and credit unions or in Title 9-A, section 4-403 with respect to supervised lenders. In conjunction with this notice, a creditor or lender shall inform its purchasers or borrowers that obtaining insurance products from a particular agent or broker does not affect credit decisions by the creditor or lender regarding the purchaser or borrower, unless the insurance product selected violates the terms of the extension of credit regarding adequacy of coverage or is otherwise not approved under section 2168, subsection 2. Another person may not interfere either directly or indirectly with the borrower's, debtor's or purchaser's free choice of an agent and of an insurer that complies with the requirements set out in section 2168 and the creditor or lender may not refuse an adequate policy so tendered by the borrower, debtor or purchaser. A creditor or lender may not reject an insurance product selected by a purchaser or borrower because the product was not obtained from or through an insurance agent or broker affiliated with the institution. For purposes of this section, the term "policy" includes, but is not limited to, any temporary contract or binder, by whatever name known, under the terms of which insurance coverage commences at a specified time, and continues until a finished policy is issued or the risk is declined and coverage is terminated. Upon notice of any refusal of this tendered policy, the superintendent shall order the creditor or lender to accept the tendered policy, if the superintendent determines that the refusal is not in accordance with the requirements set out in section 2168. Failure to comply with such an order of the superintendent is a violation of this section. [PL 1999, c. 127, Pt. A, §41 (AMD).]

This section does not apply to group health and group life insurance to the extent authorized by chapters 31 and 35 when the insured is enrolled in the insurance policy, credit life and credit health insurance to the extent authorized by chapter 37, credit property insurance, credit involuntary unemployment insurance, forced placed property insurance, a vendor's single interest policy or any other insurance product as determined by the superintendent. [PL 1997, c. 315, §26 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD). PL 1983, c. 394, §5 (AMD). PL 1993, c. 208, §1 (AMD). PL 1997, c. 315, §26 (AMD). PL 1999, c. 127, §A41 (AMD).

§2169-A. Confidentiality of insurance information obtained by lenders

1. Prohibited use of information. If a lender or creditor requires a purchaser or borrower to provide insurance information in connection with the extension of credit, an insurance agent or broker affiliated with that lender or creditor may not later use the information obtained to solicit or offer insurance directly to the purchaser or borrower. "Insurance information" means copies of insurance policies, binders, rates and expiration dates not otherwise in the possession of the agent or broker. "Affiliate" has the same meaning as set forth in section 1443-A, subsection 1, paragraph A with respect to financial institutions and credit unions or in Title 9-A, section 4-403 with respect to supervised lenders.
[PL 1999, c. 127, Pt. A, §42 (AMD).]

2. Use of information with consent. Notwithstanding subsection 1, an insurance agent or broker affiliated with a lender or creditor may use the insurance information obtained from the purchaser or borrower to solicit or offer insurance to the customer if the customer consents in writing to the use of the information. This consent may not be a condition of the extension of credit to the customer. [PL 1997, c. 315, §27 (NEW).]

3. Information permitted under Fair Credit Reporting Act. Notwithstanding subsection 1, a lender or creditor may exchange insurance information with its affiliates as permitted under the Fair Credit Reporting Act pursuant to Title 10, chapter 209-B or 15 United States Code, Chapter 41. [PL 2013, c. 588, Pt. C, §6 (AMD).]

SECTION HISTORY

PL 1997, c. 315, §27 (NEW). PL 1999, c. 127, §A42 (AMD). PL 2013, c. 588, Pt. C, §6 (AMD).

§2169-B. Use of consumer reports in insurance underwriting

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Adverse action" means a denial or cancellation of, an increase in any charge for or a reduction or other adverse or unfavorable change in the terms of coverage or amount of any insurance, existing or applied for, in connection with the underwriting of personal insurance. [PL 2003, c. 223, §1 (NEW).]

B. "Applicant" means an individual who has applied to be covered by a personal insurance policy with an insurer. [PL 2003, c. 223, §1 (NEW).]

C. "Consumer" means an individual insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or an applicant for a personal insurance policy. [PL 2003, c. 223, §1 (NEW).]

D. "Consumer report" has the same meaning as in 15 United States Code, Section 1681a(d). [PL 2013, c. 588, Pt. C, §7 (AMD).]

E. "Consumer reporting agency" has the same meaning as in Title 10, section 1308, subsection 3. [PL 2013, c. 588, Pt. C, §7 (AMD).]

F. "Credit information" means any credit-related information derived from a consumer report, found on a consumer report itself or provided on an application for personal insurance. "Credit information" does not include information that is not credit-related regardless of whether it is contained in a credit report or application or used to calculate an insurance score. [PL 2003, c. 223, §1 (NEW).]

G. "Insurance score" means a number or rating that is derived from an algorithm, computer application, model or other process that is based in whole or in part on credit information for the purposes of predicting the future loss exposure of an individual applicant or insured. [PL 2003, c. 223, §1 (NEW).]

H. "Personal insurance" means private passenger automobile, homeowners, motorcycle, mobile home owners and noncommercial dwelling fire insurance policies and boat, personal watercraft, snowmobile and recreational vehicle policies that are individually underwritten for personal, family or household use. [PL 2003, c. 223, §1 (NEW).]

[PL 2013, c. 588, Pt. C, §7 (AMD).]

2. Use of consumer reports. Notwithstanding this subsection, an insurer may use a consumer report as permitted under the Fair Credit Reporting Act pursuant to Title 10, chapter 209-B and 15 United States Code, Chapter 41. An insurer may use information obtained from a consumer reporting

agency to calculate an insurance score for underwriting and rating purposes, except that an insurer may not:

A. Use an insurance score that is calculated using race, sex, sexual orientation, gender identity, religion, ancestry or national origin, income, address, zip code or marital status of a consumer as a factor; [PL 2021, c. 553, §15 (AMD).]

B. Deny, cancel or refuse to renew a policy of personal insurance solely on the basis of credit information without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by paragraph A; [PL 2003, c. 223, §1 (NEW).]

C. Base an insured's renewal rates for personal insurance solely upon credit information, without consideration of any other applicable factor independent of credit information; [PL 2003, c. 223, §1 (NEW).]

D. Take an adverse action against a consumer solely because that consumer does not have a credit card account, without consideration of any other applicable factor independent of credit information; [PL 2003, c. 223, §1 (NEW).]

E. Consider an absence of credit information, the number of inquiries or an inability to calculate an insurance score in underwriting or rating personal insurance unless the insurer has demonstrated to the superintendent that an absence of credit information, the number of inquiries or an inability to calculate an insurance score is a relevant factor to the risk underwritten or rated by the insurer and the insurer applies this factor in a manner approved by the superintendent; or [PL 2003, c. 223, §1 (NEW).]

F. Take an adverse action against a consumer based on credit information unless an insurer obtains and uses a credit report issued or an insurance score calculated within 90 days before the date the policy is first written or renewal is issued. [PL 2003, c. 223, §1 (NEW).]

[PL 2021, c. 553, §15 (AMD).]

3. Notice of use of credit information. If credit information is used by an insurer, an insurer shall disclose, either on the insurance application or at the time the insurance application is taken, that credit information may be obtained by the insurer in connection with the application. The disclosure must be written or provided to an applicant in the same medium as the application for insurance. The insurer is not required to provide the disclosure statement required under this subsection to any insured on a renewal policy if such consumer has previously been provided a disclosure statement. An insurer may demonstrate compliance with this subsection by using the following example disclosure statement: "In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a 3rd party in connection with the development of your insurance score."

[PL 2003, c. 223, §1 (NEW).]

4. Notice of adverse action. If an insurer makes an adverse action based on credit information, the insurer shall provide the consumer with notice as required by this subsection. The insurer shall provide:

A. Notice to the consumer that an adverse action has been taken in accordance with the requirements of the Fair Credit Reporting Act pursuant to Title 10, chapter 209-B and 15 United States Code, Chapter 41; and [PL 2013, c. 588, Pt. C, §9 (AMD).]

B. Notice to the consumer explaining the reason for the adverse action. The reason or reasons must be provided in sufficiently clear and specific language so that an individual can identify the basis for the insurer's decision to take an adverse action. The notice must include a description of up to 4 factors that were the primary influences of the adverse action. The use of a generalized term such as "poor credit history," "poor credit rating" or "poor insurance score" does not meet the explanation requirements of this paragraph. Standardized credit explanations provided by

consumer reporting agencies or other 3rd-party vendors are deemed to comply with this paragraph.

[PL 2003, c. 223, §1 (NEW).]

[PL 2013, c. 588, Pt. C, §9 (AMD).]

5. Dispute resolution and error correction. If it is determined through the dispute resolution process set forth in 15 United States Code, Section 1681i(a)(5) that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of such determination from either the consumer reporting agency or from the insured, the insurer shall reunderwrite and rerate the consumer within 30 days of receiving the notice. After reunderwriting or rerating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last 12 months of coverage or the actual policy period.

[PL 2013, c. 588, Pt. C, §10 (AMD).]

5-A. Rescoring. An insurer that uses insurance scores to underwrite or rate risks, upon request of the insured but no more often than once every 12 months, shall obtain an updated credit report and recalculate the insurance score and shall reunderwrite and rerate the consumer within 30 days of receiving the request. After reunderwriting or rerating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines, on the anniversary date or the effective date of the renewal of the policy.

[PL 2007, c. 74, §1 (NEW).]

6. Filing of insurance scoring models. An insurer that uses insurance scores to underwrite and rate risks shall file the scoring model or other scoring processes used by the insurer with the superintendent. A 3rd party may file scoring models on behalf of insurers. A filing that includes insurance scoring must include loss experience justifying the use of credit information if required by the superintendent. The insurance scoring model contained in a filing required under this subsection is confidential and not a public record within the meaning of Title 1, section 402, subsection 3.

[PL 2003, c. 223, §1 (NEW).]

7. Indemnification. An insurer shall indemnify, defend and hold agents harmless from and against all liability, fees and costs arising out of or relating to the actions, errors or omissions of a producer who obtains or uses credit information or insurance scores for an insurer, provided the producer, in the exercise of reasonable care, follows the instructions of or procedures established by the insurer and complies with any applicable law or regulation. This subsection may not be construed to provide a consumer or other insured with a cause of action that does not otherwise exist in the absence of this subsection. This subsection may not be construed to indemnify a producer for the producer's omission when a producer elects not to obtain a credit-related insurance score in connection with an application for personal insurance coverage from an insurer that the producer represents if that insurer uses credit information as permitted under this section to underwrite that coverage.

[PL 2003, c. 223, §1 (NEW).]

8. Applicability. This section applies only to personal insurance. This section does not apply to commercial insurance.

[PL 2003, c. 223, §1 (NEW).]

SECTION HISTORY

PL 2003, c. 223, §1 (NEW). PL 2007, c. 74, §1 (AMD). PL 2013, c. 588, Pt. C, §§7-10 (AMD). PL 2021, c. 553, §15 (AMD).

§2170. Certain fees for handling insurance transactions in connection with loans prohibited

1. No person who makes a loan on real or personal property shall in connection with such a transaction make any separate charge to or require any fee from or require the payment of any money

for handling insurance papers for an insurer, insurance agency, borrower, mortgagor or purchaser, other than the insurance premium on insurance written as additional security for the loan. This prohibition includes any separate charge or fee or payment of any money for the substitution by a borrower or a mortgagor or a purchaser of one insurance policy on the property for an existing policy on the property when the existing or substituted policy is provided through an insurer or insurance agent or broker licensed to do business in the State.
[PL 1969, c. 132, §1 (NEW).]

2. This section does not prohibit fees paid to a lender for handling or processing credit accident and health or credit life insurance not exceeding 10% of prima facie premiums as set forth by rules adopted by the superintendent.
[PL 1993, c. 208, §2 (AMD).]

3. Nothing in this section prevents the payment of the interest which may be charged on premium loans or premium advances in accordance with the security agreement, or the payment of dividends to group policyholders provided that the payment of dividends to group credit life and group credit health policyholders shall be subject to such rules and regulations as shall be promulgated by the superintendent.
[PL 1969, c. 177, §34 (AMD); PL 1973, c. 585, §12 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1969, c. 177, §34 (AMD). PL 1973, c. 585, §12 (AMD). PL 1993, c. 208, §2 (AMD).

§2171. Using insurance information to detriment of another

Whenever the instrument requires that the purchaser, mortgagor or borrower furnish insurance of any kind on real or personal property being conveyed or as collateral security to a loan, the mortgagee or lender shall refrain from selling, transferring or otherwise disclosing or using any and all such insurance information to the mortgagee's or lender's own advantage and to the detriment of either the borrower, purchaser, mortgagor, insurer or company or agency complying with the requirements relating to insurance. [PL 1989, c. 449 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1989, c. 449 (AMD).

§2172. Fictitious groups prohibited

1. No insurer or person on behalf of any insurer shall offer, make or permit any preference or distinction for purposes of any property, casualty or, surety insurance coverage, as to form of policy, certificate, premium, rates, benefits or conditions of insurance, whether by master policy, individual policies, certificates of insurance or by any other means, based upon membership, nonmembership, or employment of any person or persons in or by, any group, association, corporation, organization or other combination of persons, based upon marketing through groups, associations, corporations, organizations or other combination of persons, or based upon a group or mass merchandising program of any kind; and shall not make any such preference or distinction available in any event based upon any fictitious grouping of persons. For the purposes of this section a fictitious grouping is defined as any grouping by other than a common insurable interest as to the subject of the insurance and the risk to be insured.
[PL 1969, c. 402, §4 (AMD).]

2. This section shall not apply as to any grouping placed in effect prior to January 1, 1968.
[PL 1969, c. 402, §4 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1969, c. 402, §4 (AMD).

§2173. Interlocking ownership; management

1. Any insurer may retain, invest in or acquire the whole or any part of the capital stock of any other insurer or insurers, or have a common management with any other insurer or insurers, unless such retention, investment, acquisition or common management is inconsistent with any other provision of this Title, or unless by reason thereof the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business or tends to create any monopoly therein.
[PL 1969, c. 132, §1 (NEW).]

2. Any person otherwise qualified may be a director of 2 or more insurers which are competitors, unless the effect thereof is to lessen substantially competition between insurers generally or tends materially to create any monopoly.
[PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2174. Illegal dealing in premiums; excess charges for insurance

1. No person shall knowingly collect any sum as premium or charge for insurance, which insurance is not then provided or is not in due course to be provided, subject to acceptance of the risk by the insurer, by an insurance policy issued by an insurer as authorized by this Title.
[PL 1969, c. 132, §1 (NEW).]

2. No person shall willfully collect as premium or charge for insurance any sum in excess of the premium or charge applicable to such insurance, and as specified in the policy, in accordance with the applicable classifications and rates as filed with and approved by the superintendent; or, in cases where classifications, premiums, or rates are not required by this Title to be so filed and approved, such premiums and charges shall not be in excess of those specified in the policy and as fixed by the insurer. This provision shall not be deemed to prohibit the charging and collection, by surplus lines brokers licensed under chapter 19, of the amount of applicable state and federal taxes and nominal service charge to cover communication expenses, in addition to the premium required by the insurer. This provision shall not be deemed to prohibit the charging and collection, by a life insurer, of amounts actually to be expended for medical examination of an applicant for life insurance or for reinstatement of a life insurance policy.
[PL 1969, c. 132, §1 (NEW); PL 1973, c. 585, §12 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD).

§2174-A. Public works employees' insurance rates

1. Definitions. For the purposes of this section, "public works employee" means a government employee, as defined by Title 14, section 8102, subsection 1, whose employment involves the care, maintenance or construction of municipally or state-owned buildings, open space, parks, parking facilities, waste water treatment systems, sewers or other property, roads, highways or other public ways. For purposes of this section, "public works employee" also includes an individual who is an independent contractor or employee of an independent contractor, under contract to the governmental entity and whose employment involves the functions listed in this subsection.
[PL 1989, c. 362 (NEW).]

2. Public works employees. No insurer may increase the premium for a personal insurance policy providing motor vehicle liability or collision insurance to a public works employee on the basis of one or more accidents involving a motor vehicle operated by that employee if:

A. The accident occurred while the employee was operating a motor vehicle in the course and scope of employment; and [PL 1989, c. 362 (NEW).]

B. There is a policy of insurance other than the personal insurance policy providing motor vehicle liability or collision coverage for the accident or accidents. [PL 1989, c. 362 (NEW); PL 1989, c. 737, §1 (AMD).]

[PL 1989, c. 362 (NEW); PL 1989, c. 737, §1 (AMD).]

3. Governmental entity. This section in no way restricts the premium an insurer may charge a governmental entity, as defined in Title 14, section 8102, subsection 2, for an insurance policy providing motor vehicle liability or collision insurance covering public works employees.

[PL 1989, c. 362 (NEW).]

SECTION HISTORY

PL 1989, c. 362 (NEW). PL 1989, c. 737, §1 (AMD).

§2174-B. Law enforcement officers' and emergency responders' insurance rates

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Law enforcement officer" means any person employed by a governmental entity who by virtue of that employment is vested by law with a duty to investigate and prosecute violators of the laws of this State and to arrest the offenders of the laws. [PL 1989, c. 737, §2 (NEW).]

B. "Emergency responder" means:

(1) A municipal firefighter, as defined in Title 30-A, section 3151, subsection 2; or a volunteer firefighter, as defined in Title 30-A, section 3151, subsection 4, who is operating a municipal vehicle; or

(2) An operator of a vehicle under Title 29-A, section 2054 that is licensed or authorized pursuant to Title 32, chapter 2-B as an ambulance or emergency medical services vehicle, when that operator is acting with the approval of an ambulance service or nontransporting service licensed pursuant to Title 32, chapter 2-B. [PL 2011, c. 493, §1 (NEW).]

[PL 2011, c. 493, §1 (AMD).]

2. Law enforcement officers; emergency responders. An insurer may not increase the premium for a personal insurance policy providing motor vehicle liability or collision insurance to a law enforcement officer or an emergency responder on the basis of one or more accidents involving a motor vehicle operated by the officer or emergency responder if:

A. The accident occurred while the officer or emergency responder was operating a motor vehicle in the course and scope of employment; and [PL 2011, c. 493, §1 (AMD).]

B. There is a policy of insurance other than the personal policy providing motor vehicle liability or collision coverage for the accident or accidents. [PL 1989, c. 737, §2 (NEW).]

[PL 2011, c. 493, §1 (AMD).]

3. Governmental entity. This section in no way restricts the premium an insurer may charge a governmental entity for an insurance policy providing motor vehicle liability or collision insurance covering law enforcement officers or emergency responders.

[PL 2011, c. 493, §1 (AMD).]

4. Penalty. An insurer who violates this section commits a civil violation pursuant to section 12-A.

[PL 1997, c. 114, §1 (NEW).]

SECTION HISTORY

PL 1989, c. 737, §2 (NEW). PL 1997, c. 114, §1 (AMD). PL 2011, c. 493, §1 (AMD).

§2175. Insurer's ownership of funeral establishment or cemetery prohibited

No insurer may own or manage or supervise or operate or maintain a mortuary establishment , a funeral establishment, a cemetery, a cemetery corporation or association, a crematorium, a mausoleum or a columbarium. [PL 1989, c. 206, §1 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1989, c. 206, §1 (AMD).

§2176. Funeral and burial service contracts

An insurer may not contract or agree with any funeral practitioner, funeral establishment, mortuary establishment, cemetery, cemetery corporation or association, crematorium, mausoleum or columbarium or any representative of any of these practitioners or establishments to the effect that the practitioner or establishment must conduct the funeral, burial or cremation or other disposal of the remains of any individual insured by the insurer. This section does not prevent compliance with Title 39-A, section 216 or the use of an insurance policy, including, subject to the provisions of section 2420, the assignment of rights under life insurance contracts, to provide security for the payment for a funeral, burial or cremation or, subject to chapter 27, the naming of a funeral establishment or funeral practitioner as beneficiary under a life insurance policy to provide payment for a funeral, burial or cremation. This section does not prohibit the use of an insurance policy as an investment by a mortuary trustee pursuant to Title 32, section 1401. [PL 2025, c. 203, §1 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1989, c. 206, §2 (AMD). PL 1991, c. 885, §E27 (AMD). PL 1991, c. 885, §E47 (AFF). PL 1999, c. 258, §1 (AMD). PL 2025, c. 203, §1 (AMD).

§2176-A. Disclosures required for sale of pre-need insurance in connection with prearranged funerals

1. Definition. For purposes of this section, "pre-need insurance" means a type of life insurance policy designed to cover the costs of funeral and burial services selected in a statement of goods and services contract and for which the entire death benefit is paid directly to the funeral establishment. [PL 2025, c. 203, §2 (NEW).]

2. Disclosures. At the time an application is made, and prior to accepting the applicant's initial premium or deposit for a pre-need insurance policy that is being sold in connection with a prearranged funeral service or plan as described in Title 32, section 1402, a producer shall adequately disclose the following information:

A. The fact that a pre-need insurance policy is involved or being used to fund a prearranged funeral service or plan; [PL 2025, c. 203, §2 (NEW).]

B. The nature of the relationship among the soliciting producer, the provider of the funeral or cemetery merchandise or services, the administrator and any other person; [PL 2025, c. 203, §2 (NEW).]

C. The relationship of the pre-need insurance policy to the funding of the prearranged funeral service or plan and the nature and existence of any guarantees relating to the prearranged funeral service or plan; [PL 2025, c. 203, §2 (NEW).]

D. A list of the goods and services that are selected or contracted for in the prearranged funeral service or plan and all relevant information concerning the price of the funeral and burial services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need; [PL 2025, c. 203, §2 (NEW).]

E. The fact that the face amount of the pre-need insurance policy may not exceed the maximum amount of the goods and services that are contracted for in the prearranged funeral service or plan; [PL 2025, c. 203, §2 (NEW).]

F. All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the pre-need insurance policy and the amount actually needed to fund the prearranged funeral service or plan; [PL 2025, c. 203, §2 (NEW).]

G. Any penalties or restrictions, including, but not limited to, geographic restrictions or the inability of the provider to perform, on the delivery of merchandise or services or the prearranged funeral service or plan guarantee; and [PL 2025, c. 203, §2 (NEW).]

H. Whether a sales commission or other form of compensation is being paid for the sale of the pre-need insurance policy and the identity of the individual or entity to whom it is paid. [PL 2025, c. 203, §2 (NEW).]

[PL 2025, c. 203, §2 (NEW).]

SECTION HISTORY

PL 2025, c. 203, §2 (NEW).

§2177. Insurer name -- deceptive use prohibited

No person who is not an insurer shall assume or use any name which deceptively infers or suggests that it is an insurer. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2178. False applications, claims, proofs of loss; penalty

No agent, broker, solicitor, examining physician, applicant or other person may knowingly or wilfully make any false or fraudulent statement or representation in or with reference to any application for insurance; or for the purpose of obtaining any money or benefit, knowingly or wilfully present or cause to be presented a false or fraudulent claim; or any proof in support of such a claim for the payment of the loss upon a contract of insurance; or prepare, make, or subscribe a false or fraudulent account, certificate, affidavit or proof of loss, or other document or writing, with intent that the same may be presented or used in support of such a claim. Persons who violate this section are subject to the penalty provided in section 12-A, or as provided by any other applicable law that provides a greater penalty. [PL 1991, c. 824, Pt. A, §50 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1991, c. 824, §A50 (AMD).

§2179. Inquests into insurance frauds

On application in writing to the superintendent by an officer of any insurer doing business in the State, stating that the officer has reason to believe and does believe that any person has, by false representations, procured from the insurer an insurance, or that the insurer has sustained a loss by the fraudulent act of the insured or with the insured's knowledge or consent, and requesting an investigation thereof, the superintendent shall summon and examine, under oath, at a time and place designated by the superintendent, any persons and require the production of all books and papers necessary for a full investigation of the facts and make report thereof, with the testimony by the superintendent taken, to the insurer making such application. [RR 2021, c. 1, Pt. B, §206 (COR).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD). RR 2021, c. 1, Pt. B, §206 (COR).

§2180. Unfair and coercive insurance requirements

No officer or employee of this State, or of any political subdivisions or quasi-municipal corporations, or of any public authority, and no person acting or purporting to act on behalf of such officer, employee or public agency or authority, except a public agency or authority created pursuant to agreement or compact with another state, shall, with respect to any public building or construction contract which is about to be or which has been competitively bid, require the bidder to make application to, or furnish financial data to, or to obtain or procure any surety bond or contract of insurance specified in connection with such contract, or specified by any law, ordinance or regulation, from a particular surety or insurance company, agent or broker. No such officer or employee, or person, firm or corporation acting or purporting to act on behalf of such officer or employee, shall negotiate, make application for, obtain or procure any such surety bond or contract of insurance, except contracts of insurance for builder's risk or owner's protective liability, which can be obtained or procured by the bidder, contractor or subcontractor. [PL 1975, c. 623, §33 (AMD).]

The same prohibition shall extend to and include any and all construction projects which are wholly or in part financed by federal, state or municipal funds. [PL 1969, c. 504, §40-A (NEW).]

This section shall not apply to any project under design or construction on January 3, 1970, by or on behalf of a public agency or authority if such agency or authority was then engaged in insurance activity with respect to such project that otherwise would be prohibited by this section. [PL 1969, c. 504, §40-A (NEW).]

SECTION HISTORY

PL 1969, c. 504, §§40-A (NEW). PL 1975, c. 623, §33 (AMD).

§2181. Exceptions

This section shall not prevent the exercise by such officer or employee on behalf of the State or such public agency or public authority of the right to approve the form, sufficiency or manner of execution of the surety bonds or contracts of insurance furnished by the surety or insurance company selected by the bidder to underwrite said bonds or contracts of insurance. [PL 1969, c. 504, §40-A (NEW).]

SECTION HISTORY

PL 1969, c. 504, §§40-A (NEW).

§2182. Application

All provisions in any invitation for bids, or in any of the contract documents, in conflict with sections 2180 and 2181 are declared to be contrary to the public policy of this State. [PL 1969, c. 504, §40-A (NEW).]

SECTION HISTORY

PL 1969, c. 504, §§40-A (NEW).

§2183. Immunity from liability

(REPEALED)

SECTION HISTORY

PL 1987, c. 345 (NEW). PL 1997, c. 341, §§1,2 (AMD). PL 1997, c. 675, §1 (RP).

§2184. Credit card charges of insurance purchases

(REPEALED)

SECTION HISTORY

PL 1991, c. 727, §1 (NEW). PL 1993, c. 135, §2 (RP).

§2185. Calculation of health benefits based on actual cost

All health insurance policies, health maintenance organization plans and subscriber contracts or certificates of nonprofit hospital or medical service organizations with respect to which the insurer or organization has negotiated discounts with providers must provide for the calculation of all covered health benefits, including without limitation all coinsurance, deductibles and lifetime maximum benefits, on the basis of the net negotiated cost and must fully reflect any discounts or differentials from charges otherwise applicable to the services provided. With respect to policies or plans involving risk-sharing compensation arrangements, net negotiated costs may be calculated at the time services are rendered on the basis of reasonably anticipated compensation levels and are not subject to retrospective adjustment at the time a cost settlement between a provider and the insurer or organization is finalized. [PL 1997, c. 197, §1 (NEW).]

SECTION HISTORY

PL 1997, c. 197, §1 (NEW).

§2186. Insurance fraud prevention

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Fraudulent insurance act" means any of the following acts or omissions when committed knowingly and with intent to defraud:

(1) Presenting, or causing to be presented, or preparing any information containing false representations as to a material fact with knowledge or belief that the information will be presented by or on behalf of an insured, claimant or applicant to an insurer, insurance producer or other person engaged in the business of insurance concerning any of the following:

(a) An application for the issuance or renewal of an insurance policy;

(b) The rating of an insurance policy;

(c) A claim for payment or benefit pursuant to an insurance policy;

(d) Payments made in accordance with an insurance policy; or

(e) Premiums paid on an insurance policy;

(2) Presenting, or causing to be presented, or preparing any information containing false representations as to a material fact with knowledge or belief that the information will be presented to or by an insurer, insurance producer or other person engaged in the business of insurance concerning any of the following:

(a) A document filed with the superintendent or the insurance regulatory official or agency of another jurisdiction;

(b) The financial condition of an insurer;

(c) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance in all or part of this State by an insurer;

(d) The issuance of written evidence of insurance; or

(e) The reinstatement of an insurance policy;

(3) Soliciting or accepting new or renewal insurance risks on behalf of an insurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction;

(4) Removing, concealing, altering or destroying the assets or records of an insurer or other person engaged in the business of insurance;

(5) Embezzling, abstracting, purloining or converting money, funds, premiums, credits or other property of an insurer or other person engaged in the business of insurance;

(6) Transacting the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance; or

(7) Attempting to commit, aiding or abetting in the commission of, or conspiring to commit the acts or omissions described in this subsection. [PL 1997, c. 675, §2 (NEW).]

B. "Insurer" means an authorized insurance company, fraternal benefit society, reinsurer, surplus lines insurer, unauthorized insurer, nonprofit hospital and medical service organization, health maintenance organization, risk retention group or multiple employer welfare organization. "Insurer" also includes an insurance producer or other person acting on the behalf of an insurer. For the purposes of this section, "insurer" also means the state Medicaid program. [PL 2009, c. 13, §2 (AMD).]

[PL 2009, c. 13, §2 (AMD).]

2. Fraudulent insurance acts prohibited. A person may not commit a fraudulent insurance act. [PL 1997, c. 675, §2 (NEW).]

3. Fraud warning required. Fraud warnings are required in accordance with the following.

A. All applications and claim forms for insurance used by insurers in this State, regardless of the form of transmission, must contain the following statement or a substantially similar statement permanently affixed to the application or claim form: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits." [PL 1997, c. 675, §2 (NEW).]

B. The lack or omission of the statement required in paragraph A does not constitute a defense in any criminal prosecution or civil action for a fraudulent insurance act. [PL 1997, c. 675, §2 (NEW).]

C. This subsection applies to all insurers except reinsurers. The statement required in paragraph A must be included in all applications and claim forms filed and approved for use by the superintendent on or after January 1, 1999. [PL 1997, c. 675, §2 (NEW).]

[PL 1997, c. 675, §2 (NEW).]

4. Reporting of fraudulent insurance acts. Fraudulent insurance acts must be reported in accordance with this subsection.

A. An insurer shall, annually on or before March 1st or within any reasonable extension of time granted by the superintendent, file with the superintendent a report relating to fraudulent insurance acts that the insurer knew or reasonably believed had been committed during the previous calendar year. The report must contain information required by the superintendent in the manner prescribed by the superintendent. The information must be reported on an aggregate basis and may not contain any information identifying any individuals or entities. The superintendent shall adopt by January 1, 1999 rules necessary to define the information that must be reported. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [PL 1997, c. 675, §2 (NEW).]

B. On the July 1st following the filing of the initial reports required by paragraph A, and annually thereafter, the superintendent shall report to the joint standing committee of the Legislature having jurisdiction over insurance matters. The report must include aggregate information detailing the fraudulent insurance activity experienced by insurers in this State. [PL 1997, c. 675, §2 (NEW).]

[PL 1997, c. 675, §2 (NEW).]

5. Insurer antifraud plans. Within 6 months of the effective date of this Act, every insurer writing direct insurance shall prepare and implement an antifraud plan. This subsection does not apply to any agency, producer or other person acting on behalf of an insurer. The superintendent may review an insurer's antifraud plan to determine if the plan complies with the requirements of this subsection. The antifraud plan must outline specific procedures, appropriate to the lines of insurance the insurer writes in the State, to:

A. Prevent, detect and investigate all forms of insurance fraud; [PL 1997, c. 675, §2 (NEW).]

B. Educate appropriate employees on the antifraud plan and fraud detection; [PL 1997, c. 675, §2 (NEW).]

C. Provide for the hiring of or contracting for fraud investigators; and [PL 1997, c. 675, §2 (NEW).]

D. Report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud. [PL 1997, c. 675, §2 (NEW).]

[PL 1997, c. 675, §2 (NEW).]

6. Civil penalties. Any violation of this section is subject to civil penalties and other remedies as provided in section 12-A. Notwithstanding section 2165-A, subsection 1, the superintendent may issue emergency cease and desist orders on the basis of conduct involving fraudulent insurance acts.
[PL 1997, c. 675, §2 (NEW).]

7. Recovery costs. In a civil action in which it is proven that a person committed a fraudulent insurance act, the court may award reasonable attorney's fees and costs to the insurer. In a civil action in which the insurer alleges that a party committed a fraudulent insurance act that is not established at trial, the court may award reasonable attorney's fees and costs to the party if the allegation is not supported by any reasonable basis of law or fact.
[PL 1997, c. 675, §2 (NEW).]

SECTION HISTORY

PL 1997, c. 675, §2 (NEW). PL 1999, c. 5, §1 (AMD). PL 1999, c. 5, §2 (AFF). PL 2009, c. 13, §2 (AMD).

§2187. Insurance fraud reporting immunity

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Action" includes nonaction or the failure to take action. [PL 1997, c. 675, §2 (NEW).]

B. "Authorized agency" or "authorized agencies" means:

(1) The Attorney General;

(2) A district attorney responsible for prosecution in the municipality where the fraud occurred;

(3) The Federal Bureau of Investigation, or any other federal agency, only for the purposes of subsection 2;

(4) The State Fire Marshal;

(5) The Superintendent of Insurance;

(6) The Superintendent of Financial Institutions;

(7) The United States Attorney's office when authorized or charged with investigation or prosecution of the insurance fraud in question, only for the purposes of subsection 2;

(8) The State Police, state law enforcement officials or local law enforcement officials; or

(9) The National Association of Insurance Commissioners. [PL 2005, c. 433, §1 (AMD); PL 2005, c. 433, §28 (AFF).]

C. "Fraudulent insurance act" has the same meaning as in section 2186, subsection 1, paragraph A. [PL 1997, c. 675, §2 (NEW).]

D. "Insurer" has the same meaning as in section 2186, subsection 1, paragraph B. [PL 1997, c. 675, §2 (NEW).]

[PL 2005, c. 433, §1 (AMD); PL 2005, c. 433, §28 (AFF).]

2. Information disclosed. An authorized agency investigating insurance fraud may, in writing, require the insurance company at interest to release to the requesting agency any relevant information or evidence determined to be important to the authorized agency that the company may have in its possession relating to the insurance fraud in question. This information includes, but is not limited to:

A. A history of previous claims made by the insured; [PL 1997, c. 675, §2 (NEW).]

B. Insurance policy information relevant to fraud under investigation and any application for that policy; [PL 1997, c. 675, §2 (NEW).]

C. Material relating to the investigation of the loss including statements and proof of loss; and [PL 1997, c. 675, §2 (NEW).]

D. Policy premium payment records. [PL 1997, c. 675, §2 (NEW).]

[PL 1997, c. 675, §2 (NEW).]

3. Exchange of information. An authorized agency or insurer provided with information pursuant to this section may release or provide that information to any other authorized agency or insurer with an interest in the insurance fraud under investigation.

[PL 1997, c. 675, §2 (NEW).]

4. Right to receive upon request. Any insurer providing information to an authorized agency pursuant to this section has the right, upon request, to receive other information relevant to the fraud from that authorized agency within 30 days.

[PL 1997, c. 675, §2 (NEW).]

5. Immunity. In the absence of fraud, malice or bad faith, any person, including, but not limited to, an insurer or authorized agency, that furnished information relating to suspected, anticipated or completed fraudulent insurance acts is not liable for any damages in any civil action for furnishing the information if that information is furnished to or received from an authorized agency. Nothing in this subsection is intended to abrogate or modify in any way any common law or statutory privilege or immunity previously enjoyed by any person.

[PL 1997, c. 675, §2 (NEW).]

6. Confidentiality. An authorized agency or insurer that receives any information pursuant to this section shall hold it in confidence and may not release the information, except to another authorized agency, until its release is required for a criminal or civil proceeding.

[PL 1997, c. 675, §2 (NEW).]

SECTION HISTORY

PL 1997, c. 675, §2 (NEW). PL 2001, c. 44, §11 (AMD). PL 2001, c. 44, §14 (AFF). PL 2005, c. 433, §1 (AMD). PL 2005, c. 433, §28 (AFF).

§2188. Permitted activities of insurance producers; navigators; requirements

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Exchange" means a health benefit exchange established or operated in this State, including a health benefit exchange established or operated by the Secretary of the United States Department of Health and Human Services, pursuant to Section 1311 of the federal Affordable Care Act. [PL 2011, c. 631, §1 (NEW).]

B. "Navigator" means a person selected to perform the activities and duties identified in Section 1311(i) of the federal Affordable Care Act. For the purposes of this section, if an organization or business entity serves as a navigator, an individual performing navigator duties for that organization or business entity is considered to be acting in the capacity of a navigator within the meaning of subsection 4. [PL 2011, c. 631, §1 (NEW).]

[PL 2011, c. 631, §1 (NEW).]

2. Prohibited activities. Certification as a navigator under this section does not authorize a person who is not licensed as an insurance producer or consultant in this State in accordance with chapter 16 to act as an insurance producer or consultant. Regardless of whether a navigator certified under this section is also licensed as an insurance producer or consultant in this State in accordance with chapter 16, a navigator may not, while acting as a navigator for an individual, enrollee, potential enrollee or employer:

A. Sell, solicit or negotiate insurance; [PL 2013, c. 388, Pt. A, §1 (AMD).]

B. Make recommendations to purchasers, enrollees or employers or prospective purchasers or enrollees to choose or reject a particular health plan; or [PL 2013, c. 388, Pt. A, §1 (AMD).]

C. Enroll an individual or employee in a qualified health plan offered through an exchange or act as an intermediary between an employer and an insurer that offers a qualified health plan offered through an exchange, except that the actions of a navigator to provide assistance to an individual or employee to facilitate that individual's or employee's enrollment in a qualified health plan is not considered enrolling an individual or employee in a qualified health plan under this paragraph. [PL 2013, c. 388, Pt. A, §1 (AMD).]

[PL 2013, c. 388, Pt. A, §1 (AMD).]

3. Certification of navigators. Prior to any exchange becoming operational in this State, the superintendent shall:

A. [PL 2013, c. 388, Pt. A, §1 (RP).]

B. Adopt rules to establish a certification program for individual navigators who are not licensed as insurance producers and training requirements for all individual navigators and prospective individual navigators that include initial and continuing education requirements and an examination. [PL 2013, c. 388, Pt. A, §1 (AMD).]

C. [PL 2013, c. 388, Pt. A, §1 (RP).]

[PL 2013, c. 388, Pt. A, §1 (AMD).]

4. Navigator requirements. An individual may not act in the capacity of a navigator unless the individual is either licensed as an insurance producer under chapter 16 or certified by the superintendent as a navigator under this section. To be certified as a navigator, an individual must:

A. Be at least 18 years of age; [PL 2013, c. 388, Pt. A, §1 (AMD).]

B. Have completed and submitted a disclosure form, which must be developed by the superintendent and which may include such information as the superintendent determines necessary, and have declared under penalty of refusal, suspension or revocation of the navigator certification that the statements made in the form are true, correct and complete to the best of the individual's knowledge and belief; [PL 2013, c. 388, Pt. A, §1 (AMD).]

C. Have submitted to any criminal history record check or regulatory background check required by the superintendent by rule; [PL 2013, c. 388, Pt. A, §1 (AMD).]

D. [PL 2013, c. 388, Pt. A, §1 (RP).]

E. Have successfully completed the initial training requirements and any other certification requirements adopted by the superintendent in accordance with subsection 3; and [PL 2013, c. 388, Pt. A, §1 (AMD).]

F. Have paid any fees required by the superintendent. [PL 2013, c. 388, Pt. A, §1 (AMD).]
[PL 2013, c. 388, Pt. A, §1 (AMD).]

5. Unfair practices. The provisions of this chapter and any rules adopted pursuant to this chapter apply to navigators. This subsection may not be construed to create or imply a private cause of action for a violation of any provision of this chapter.
[PL 2013, c. 388, Pt. A, §1 (AMD).]

5-A. Privacy. A navigator may not collect, use, disclose or retain personal information, as defined in section 2204, subsection 20, except for the purposes of performing the duties of a navigator or as permitted by an exchange under privacy standards adopted in accordance with the federal Affordable Care Act. A navigator is a regulated insurance entity for purposes of chapter 24 only if the navigator collects, uses, discloses or retains personal information for purposes other than performing the duties of a navigator.
[PL 2013, c. 388, Pt. A, §1 (NEW).]

6. Denial, suspension or revocation. The superintendent may deny certification and may suspend or revoke the authority of a navigator certified pursuant to this section for any ground specified in section 1420-K, subsection 1. The superintendent may assess civil penalties in accordance with section 12-A for violations of laws regulating the activities of navigators.
[PL 2013, c. 388, Pt. A, §1 (AMD).]

7. Rules. The superintendent may adopt rules as necessary to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2011, c. 631, §1 (NEW).]

8. Construction. This section may not be construed to prevent the application of any provisions of the federal Affordable Care Act relating to the duties of a navigator.
[PL 2013, c. 388, Pt. A, §1 (NEW).]

SECTION HISTORY

PL 2011, c. 631, §1 (NEW). PL 2013, c. 388, Pt. A, §1 (AMD).

§2189. Requirements related to enrollment in health plans

1. Definition. As used in this section, unless the context otherwise indicates, "exchange" has the same meaning as in section 2188, subsection 1, paragraph A.
[PL 2017, c. 60, §1 (NEW); PL 2017, c. 60, §2 (AFF).]

2. Requirements. An insurer that offers a health plan in this State through the exchange or outside of the exchange shall pay a commission to a licensed insurance producer appointed by or contracted with the insurer for the enrollment of an individual or employee in a health plan during any annual or special enrollment period.

A commission paid to a licensed insurance producer appointed by or contracted with the insurer for enrollment in a health plan during any special enrollment period must be equal to the commission paid for enrollment during the insurer's annual enrollment period.
[PL 2017, c. 60, §1 (NEW); PL 2017, c. 60, §2 (AFF).]

3. Commission on health plan enrollment initially completed during special enrollment period. An insurer may not eliminate, restrict or limit the payment of a commission to a licensed

insurance producer appointed by or contracted with the insurer for the enrollment of an individual or employee in a health plan during any annual enrollment period on the basis that the producer was not paid a commission for the enrollment of the same individual or employee by the producer in a prior plan year during a special enrollment period.

[PL 2017, c. 60, §1 (NEW); PL 2017, c. 60, §2 (AFF).]

SECTION HISTORY

PL 2017, c. 60, §1 (NEW). PL 2017, c. 60, §2 (AFF).