STATE OF CONNECTICUT *v.* ACORDIA, INC.
(SC 18756)

Rogers, C. J., and Norcott, Palmer, Zarella, Eveleigh, Harper and Vertefeuille, Js.*

Argued September 18, 2012—officially released August 27, 2013

Alan L. Kildow, pro hac vice, with whom were *Mitchell R. Harris* and, on the brief, *Sonya R. Braunschweig*, pro hac vice, for the appellant (defendant).

Matthew J. Budzik, assistant attorney general, with whom were *George W. O'Connell* and *Kirsten S.P. Rigney*, assistant attorneys general, and, on the brief, *George Jepsen*, attorney general, for the appellee (plaintiff).

Opinion

VERTEFEUILLE, J. The plaintiff, the state of Connecticut, brought this action against the defendant, Acordia, Inc., pursuant to General Statutes § 42-110m, alleging that the defendant's failure to disclose to its clients certain contingent commission agreements that it had entered into with insurance companies violated the Connecticut Unfair Trade Practices Act (CUTPA); General Statutes § 42-110a et seq.; and the Connecticut Unfair Insurance Practices Act (CUIPA). General Statutes § 38a-815 et seq. Following a court trial, the court rendered judgment in favor of the plaintiff, concluding that the defendant's actions violated both CUTPA and CUIPA. The defendant appeals[1] from the judgment of the trial court, claiming that the court improperly relied on its conclusion that the defendant had breached a fiduciary duty owed to its clients to determine that the defendant violated CUIPA. General Statutes § 38a-816 (1) and (2).[2] The defendant further contends that if this court concludes that the trial court improperly concluded that the defendant violated CUIPA, the CUTPA violation cannot stand. We agree with the defendant that the trial court improperly concluded that the defendant violated CUIPA. We further conclude that, in the absence of a CUIPA violation, the CUTPA claim must fail in the context of the present case. Accordingly, we reverse the judgment of the trial court.[3]

The trial court found the following pertinent facts. During the relevant time period between 1999 and 2002, the defendant, an independent insurance broker headquartered in Chicago, Illinois, offered its clients insurance products from multiple insurance companies. The defendant operated a decentralized organization with 75 to 100 local offices throughout the United States. The local offices, each of which was a separate corporate entity, employed approximately 1000 producers. Producers are the individuals in the industry who have direct contact with clients, cultivate personal relationships with them and assist them in selecting insurance policies that best meet the clients' needs. The defendant sold insurance only through these local offices and producers. Although the defendant did not maintain a local office in Connecticut, it solicited customers in Connecticut and sold and serviced insurance products to Connecticut consumers through its offices in New Jersey, New York and Massachusetts, among other states.

Insurance companies sell their products in one of two ways, either directly or through an agent or broker. Brokers may be either "captive" or "independent." A captive broker offers products only from a particular insurance company. By contrast, an independent broker, such as the defendant, offers its clients a choice of policies from multiple insurance companies. Independent brokers are compensated for their services either by a fee charged directly to the consumer or by

a commission, the cost of which is included in the premium.

In 1999, the defendant proposed a three year program to the twenty insurance companies with which it placed the most business; the program was called the "millennium partnership program" (program). Insurers who chose to participate in the program (participating insurers) agreed to pay on a quarterly basis 1 percent of the total value of the premiums that the defendant placed with that company, in addition to any commission already paid to the defendant. In exchange for this payment, Charles Ruoff, the defendant's chief marketing officer, represented to prospective participants that participating insurers would be given "priority status" and would "have the opportunity under the [program] to quote more business through [the defendant] to [the defendant's] clients and sell more insurance." Ruoff also told prospective participants that producers at the local offices would be informed of their priority status. Five insurers agreed to participate in the program: The Travelers Indemnity Company, The Hartford Fire Insurance Company, Chubb Group of Insurance Companies, Atlantic Mutual Insurance Company and Royal & Sun Alliance Insurance Company. Subsequently, Kevin Conboy, the defendant's east regional director, instructed executive management that the participating insurers "should be given preferential consideration on new and renewal placements."

The defendant's clients were never informed of the existence of the program. Four Connecticut consumers who were clients of the defendant testified at trial that they had never heard of the program. They also testified that they relied on their broker—in each instance a producer employed by one of the defendant's subsidiaries—to provide them with independent and unbiased advice regarding the purchase of insurance coverage.

Despite Ruoff's assurances to the participating insurers, the plaintiff failed to prove at trial that producers in fact had been informed of the program. Of the four producers who testified at trial, three had never heard of the program or of the contingent commissions, and the fourth testified only that he "may have heard about it." Additionally, the plaintiff failed to prove that any of the producers steered their clients toward participating insurers or did anything other than act in the clients' best interests in assisting them to obtain insurance. Moreover, the court found that the plaintiff failed to prove that any clients suffered any individual monetary harm from the failure to disclose the program, and, instead found that clients paid the same insurance premiums that they would have paid if the program had not existed.[4]

In 2006, at the request of the Commissioner of Consumer Protection for the state of Connecticut, pursuant to § 42-110m (a),[5] the plaintiff brought this action.[6] After

trial, the court, having concluded that the defendant had breached a fiduciary duty owed to its clients and that this breach violated both CUTPA and CUIPA, rendered judgment in favor of the plaintiff and ordered only that the defendant "account for nondisclosed [program] based commissions for products purchased by consumers in the state of Connecticut." The court denied the plaintiff's request for injunctive relief. See footnote 6 of this opinion. The court subsequently denied the plaintiff's motion seeking an articulation of the scope of the ordered accounting. This appeal followed.

The defendant claims that the trial court improperly incorporated the concept of fiduciary duty into its analysis of whether the defendant had violated CUIPA and rested its conclusion that the defendant had violated CUIPA solely on its finding of a violation of fiduciary duty. Furthermore, the defendant argues, the lack of a CUIPA violation is fatal to the plaintiff's CUTPA claim. The plaintiff responds that the court did not predicate its conclusion that the defendant violated CUIPA on any fiduciary duty owed by the defendant to its clients. Rather, the plaintiff contends, the defendant mischaracterizes the rationale of the trial court in so arguing. Additionally, the plaintiff claims that its CUTPA claim does not stand or fall with the CUIPA violation because a CUIPA violation is not a necessary predicate to the conclusion that an insurer violated CUTPA. We agree with the defendant that the court improperly relied on the concept of fiduciary duty in concluding that the defendant violated CUIPA. We further conclude that, in the absence of a valid CUIPA claim in the present case, the plaintiff's CUTPA claim must fail.

I

The defendant challenges the trial court's conclusion that it violated CUIPA on the basis that in doing so, the court improperly determined that breach of a fiduciary duty constitutes a violation of CUIPA. The plaintiff asserts that the defendant mischaracterizes the rationale of the trial court, which the plaintiff reads as identifying and ruling on two independent claims: a claim that the defendant violated CUTPA by breaching its fiduciary duty to disclose a conflict of interest to its clients, and a claim that the defendant violated CUIPA by engaging in conduct that was misleading or deceptive. Although the trial court's memorandum of decision is not entirely clear as to the basis for its conclusion that the defendant violated CUIPA, we believe that the defendant's reading of the decision is more accurate. We therefore agree that the court improperly predicated its conclusion that the defendant violated CUIPA on the court's determination that the defendant had breached a fiduciary duty owed to its clients.

This issue presents a question of law, over which our review is plenary. See *Fisher* v. *Big Y Foods, Inc.*, 298 Conn. 414, 423–24, 3 A.3d 919 (2010) ("[T]he scope of

our appellate review depends [on] the proper characterization of the rulings made by the trial court. To the extent that the trial court has made findings of fact, our review is limited to deciding whether such findings were clearly erroneous. When, however, the trial court draws conclusions of law, our review is plenary and we must decide whether its conclusions are legally and logically correct and find support in the facts that appear in the record." [Internal quotation marks omitted.]).

In order to resolve the dispute between the parties as to the proper understanding of the rationale of the trial court as it pertains to the court's conclusion that the defendant violated CUIPA, we examine in detail the court's discussion of fiduciary duty. The court introduced the principle of fiduciary duty in the course of its consideration of the plaintiff's CUTPA claim, and began that analysis by observing that "a violation of CUTPA may be established by showing . . . a practice amounting to a violation of public policy." (Citation omitted; internal quotation marks omitted.) *Daddona* v. *Liberty Mobile Home Sales, Inc.*, 209 Conn. 243, 254, 550 A.2d 1061 (1988). To make the required showing, the court noted, a litigant must show that the challenged practice "without necessarily having been previously considered unlawful, offends public policy as it has been established by statutes, the common law, or otherwise . . . ." (Internal quotation marks omitted.) *Cheshire Mortgage Service, Inc.* v. *Montes*, 223 Conn. 80, 105–106, 612 A.2d 1130 (1992). The court then turned to the common law for the source of the public policy violation, setting forth principles of agency and fiduciary duty. The court concluded that the defendant owed a fiduciary duty to its clients, based on its findings that the defendant had held itself out to clients as independent, sought to establish a relationship of trust and confidence with clients, and encouraged clients to expect that the defendant would act in their best interests. The court next concluded that the defendant breached that fiduciary duty by failing to disclose the existence of the program to its clients. The court reasoned that the program created a conflict of interest for the defendant between the incentive created by the program to direct clients toward products offered by the participating insurers and the duty that the defendant owed to the clients to make recommendations solely based on the clients' best interests, consistent with the relationships of trust and confidence established between producers and clients. In light of the existence of a fiduciary duty, the court concluded that the failure to disclose the conflict of interest amounted to a betrayal of the trust and confidence that the clients placed in the defendant. Accordingly, the court concluded that the defendant's failure to disclose that conflict of interest "violated Connecticut's public policy of respecting fiduciary obligations as that policy existed

in 1999–2002" and that by doing so the defendant had "engaged in conduct prohibited under CUTPA."

The trial court next considered the defendant's claim that even if the court concluded that the defendant's conduct constituted a breach of fiduciary duty in violation of public policy, the plaintiff could not prevail in its CUTPA claim, because it had failed to prove that the defendant's conduct violated CUIPA. The court explained its interpretation of this court's holding in *Mead* v. *Burns*, 199 Conn. 651, 509 A.2d 11 (1986), namely, that when a party seeks to hold a defendant in the insurance industry liable under CUTPA, that party bears the burden "to prove that the CUTPA claim is also a CUIPA violation." Having concluded that the plaintiff had established its CUTPA claim—that the defendant's conduct violated CUTPA because it violated the state's public policy requiring adherence to fiduciary duty—the court turned to the question of whether that violation also violated CUIPA. The court then stated in a conclusory manner that the defendant's "nondisclosure of the existence of the [program] to its customers was 'deceptive or misleading' as those terms are used in CUIPA." The *only* analysis supporting that conclusion is the court's discussion of the defendant's alleged breach of fiduciary duty and its statement that the plaintiff bore the burden to prove that the CUTPA violation—a violation of the public policy requiring adherence to fiduciary duty—was also a CUIPA violation. Our reading of the trial court's decision, therefore, is that the court predicated its conclusion that the defendant violated CUIPA on its determination that the defendant breached a fiduciary duty owed to its clients.

We now turn to the defendant's substantive claim, that is, whether the trial court properly relied on the common-law principle of fiduciary duty to conclude that the defendant's actions violated CUIPA. Put another way, we must examine whether the court properly looked beyond the confines of CUIPA itself and relied on the common law to conclude that the defendant's actions constituted an unfair insurance practice. To the extent that this question requires us to consider whether the legislature intended CUIPA to serve as the comprehensive and exclusive means of identifying unfair insurance practices, it involves a question of statutory interpretation. "The process of statutory interpretation involves the determination of the meaning of the statutory language as applied to the facts of the case, including the question of whether the language does so apply. . . . When construing a statute, [o]ur fundamental objective is to ascertain and give effect to the apparent intent of the legislature. . . . [General Statutes] § 1-2z directs us first to consider the text of the statute itself and its relationship to other statutes. If, after examining such text and considering such relationship, the meaning of such text is plain and unambiguous and does not yield absurd or unworkable results, extratextual

evidence of the meaning of the statute shall not be considered. . . . When a statute is not plain and unambiguous, we also look for interpretive guidance to the legislative history and circumstances surrounding its enactment, to the legislative policy it was designed to implement, and to its relationship to existing legislation and common law principles governing the same general subject matter . . . . A statute is ambiguous if, when read in context, it is susceptible to more than one reasonable interpretation." (Internal quotation marks omitted.) *Hartford/Windsor Healthcare Properties, LLC* v. *Hartford*, 298 Conn. 191, 197–98, 3 A.3d 56 (2010).

We begin with the language of CUIPA. Section 38a-815 provides in relevant part: "No person shall engage in this state in any trade practice which is defined in section 38a-816 as, or determined pursuant to sections 38a-817 and 38a-818 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance . . . . The [Insurance] [C]ommissioner shall have power to examine the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by sections 38a-815 to 38a-819, inclusive. . . ." Section 38a-815 thus identifies two different ways in which a practice may be determined to be an unfair insurance practice in violation of CUIPA: the practice may fall under one of the defined unfair insurance practices in § 38a-816, or the Insurance Commissioner (commissioner) may determine, pursuant to General Statutes §§ 38a-817 and 38a-818, that the practice constitutes "an unfair method of competition or an unfair or deceptive act or practice in the business of insurance . . . ." General Statutes § 38a-815.

The next provision of the statutory scheme identifies certain practices that "are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance . . . ." General Statutes § 38a-816; see footnote 2 of this opinion. The twenty-two subdivisions now codified in § 38a-816 list a broad array of different practices. To illustrate the breadth of that list, we observe in brief summary that those practices include misrepresentations and false advertising of insurance policies; false advertising generally; defamation; boycotts; coercion and intimidation; false financial statements; unfair claim settlement practices; failure to maintain complaint handling procedures; misrepresentation in insurance applications; any violation of General Statutes §§ 38a-358, 38a-446, 38a-447, 38a-488, 38a-825, 38a-826, 38a-828, 38a-829, 38a-465 to 38a-465q, 38a-478 or 42-260; denial of reimbursement on the basis of race, color or creed, or unfair discrimination against licensed practitioners of the healing arts; coercion of debtors; discrimination in provision of insurance on the basis of physical disability, mental

retardation, blindness, exposure to diethylstilbestrol, genetic information, or being a victim of family violence; failure to pay a health care provider within defined time periods; when a motor vehicle has been declared to be a total constructive loss, failure to pay one of certain defined amounts under an automobile insurance policy; and, with respect to a managed care organization, failure to establish a confidential procedure for medical record information.

It is important to observe that, in addition to setting forth a broad array of practices, § 38a-816 defines each listed practice in specific detail. For example, § 38a-816 (1), which addresses misrepresentations and false advertising of insurance policies, includes "[m]aking, issuing or circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison which: (A) [m]isrepresents the benefits, advantages, conditions or terms of any insurance policy; (B) misrepresents the dividends or share of the surplus to be received, on any insurance policy; (C) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; (D) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates; (E) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; (F) is a misrepresentation, including, but not limited to, an intentional misquote of a premium rate, for the purpose of inducing or tending to induce to the purchase, lapse, forfeiture, exchange, conversion or surrender of any insurance policy; (G) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or (H) misrepresents any insurance policy as being shares of stock." This subdivision thus carefully delineates the specific means of dissemination that come within the definition of "[m]isrepresentations and false advertising" and specifies the types of representations that can qualify as misleading under the statute, providing a very detailed description of which types of practices the legislature intended to include under the category of "[m]isrepresentations and false advertising of insurance policies." General Statutes § 38a-816 (1).

The itemization of different types of unfair insurance practices in § 38a-816 is significant. We have stated that "[u]nless there is evidence to the contrary, statutory itemization indicates that the legislature intended the list to be exclusive." (Internal quotation marks omitted.) *Bridgeport Hospital* v. *Commission on Human Rights & Opportunities*, 232 Conn. 91, 101, 653 A.2d 782 (1995). In addition, § 38a-816 is not merely a list, it expressly identifies itself as a *definitional* statute. The introductory sentence of that statute provides that "[t]he following are defined" as unfair insurance prac-

tices. General Statutes § 38a-816. By framing the list as a definitional one, the legislature already constrained the discretion of courts to look to other sources in finding a particular insurance practice to be "unfair" in violation of CUIPA. "When legislation contains a specific definition, the courts are bound to accept that definition." *International Business Machines Corp.* v. *Brown*, 167 Conn. 123, 134, 355 A.2d 236 (1974). This stands in sharp contrast to a list that recites that the category "includes" the following, thereby suggesting that items not listed might also come within the category.

Section 38a-816 does not, however, expressly provide that the list is intended to be exclusive, and, as we already have observed, § 38a-815 provides that the commissioner may determine, pursuant to §§ 38a-817 and 38a-818, that a particular practice constitutes an unfair insurance practice in violation of CUIPA. Both sections suggest that the *commissioner* has the authority to recognize a violation of CUIPA notwithstanding the failure of the particular practice at issue to conform to any of the defined practices in § 38a-816.

Sections 38a-817 and 38a-818 authorize the commissioner to conduct a hearing to determine whether a party has engaged in an unfair or deceptive insurance practice in violation of CUIPA. Both sections recognize the commissioner's authority to determine that the practice at issue violates CUIPA, notwithstanding the failure of the practice to come within one of the defined practices listed in § 38a-816. The commissioner may proceed under § 38a-817 (a) "[w]henever the commissioner has reason to believe that any such person has been engaged or is engaging in violation of sections 38a-815 to 38a-819, inclusive, in any unfair method of competition or any unfair or deceptive act or practice defined in section 38a-816, and that a proceeding by the commissioner in respect thereto would be in the interest of the public . . . ." Following the hearing, if the commissioner determines that the practice is an unfair or deceptive insurance practice in violation of CUIPA, but is not one of the defined practices in § 38a-816, the commissioner may issue a cease and desist order. If the commissioner determines that the practice is one of the defined practices in § 38a-816, the commissioner may order additional penalties and remedies. General Statutes § 38a-817 (b).

Section 38a-818, the companion provision to § 38a-817, authorizes the commissioner to conduct a hearing "in the same manner as the hearings provided for in section 38a-817," "[w]henever the commissioner has reason to believe that any person engaged in the business of insurance is engaging in this state in any method of competition or in any act or practice in the conduct of such business *which is not defined in section 38a-816*, that such method of competition is unfair or that

such act or practice is unfair or deceptive and that a proceeding by him in respect thereto would be to the interest of the public . . . ." (Emphasis added.) General Statutes § 38a-818. If the commissioner determines that the practice violates General Statutes §§ 38a-815 to 38a-819, inclusive, he may file a petition in Superior Court seeking an order enjoining or restraining the person from engaging in the practice at issue. General Statutes § 38a-818.

Sections 38a-817 and 38a-818, read together with §§ 38a-815 and 38a-816, suggest that the legislature intended to provide in § 38a-816 a comprehensive list of insurance practices that are unfair or deceptive in violation of CUIPA, but that it recognized the need to authorize the commissioner to act in the event that a person is engaging in a practice that had not yet been defined expressly as an unfair insurance practice in § 38a-816, but that could possibly, following a hearing conducted by the commissioner, be determined to constitute an unfair or deceptive insurance practice. It is also significant that the statutory scheme confers upon the commissioner different levels of authority to act, depending on whether the commissioner has reason to believe that the person is engaging in a practice that violates § 38a-816, and, subsequently, whether the commissioner determines that said practice violates § 38a-816. The existence of a violation of § 38a-816 is the standard by which the commissioner's authority to investigate, and subsequently, to order further procedures, remedies or penalties, is statutorily determined. It is also significant that nowhere in §§ 38a-815 to 38a-819, inclusive, is the Superior Court authorized to act in the absence of a violation of § 38a-816, unless the commissioner first has made the requisite finding that a person or entity has violated CUIPA by engaging in an unfair or deceptive insurance practice that is not defined in § 38a-816.

There is nothing in the record of the present case that reveals that the commissioner initiated any proceedings against the defendant pursuant to the authority established in §§ 38a-817 and 38a-818, which, accordingly, are not at issue in the present case. The question we must address, therefore, is whether the legislature intended § 38a-816 to preclude the courts from determining that a party engaged in an unfair insurance practice in violation of CUIPA based on legal authority other than § 38a-816, specifically, the common law. With respect to that question, although the statutory language strongly suggests an answer in the affirmative, we cannot say that the language is plain and unambiguous. Accordingly, we turn to the origin and history of the statutory scheme of CUIPA for further guidance. CUIPA was enacted in 1955 and was based on a model insurance trade practices act promulgated by the National Association of Insurance Commissioners in 1947. *Mead* v. *Burns*, supra, 199 Conn. 659. The impetus behind both

the promulgation of the model act and the subsequent enactment of CUIPA was "to preempt federal regulation." Id. During the floor debate of House Bill No. 978, Representative J. Frederick Bitzer explained that there was a need to have a statute that set forth in detail the powers of the commissioner with respect to unfair trade practices in the insurance industry, noting that doing so would "bar the Federal Trade Commission from entering into the field of supervising [this area] which properly belongs to the [I]nsurance [C]ommissioner." 6 H.R. Proc., Pt. 2, 1955 Sess., p. 1037; see also Conn. Joint Standing Committee Hearings, Insurance, 1955 Sess., p. 37, remarks of W. Ellery Allyn ("[t]he reason this bill is in is because of the Federal Trade Commission's indication that they will move in on certain matters if they are not regulated by the [s]tate"). From the outset, therefore, the legislative intent in passing CUIPA was to occupy the field with regard to unfair trade practices in the insurance industry.

The legislature's intent to define comprehensively unfair insurance practices in this state is further evidenced by subsequent amendments to CUIPA. Number 73-73 of the 1973 Public Acts enacted the most significant revisions to CUIPA. Testifying before the Insurance Committee regarding the proposed changes, the Insurance Commissioner at the time, Paul B. Altermatt, explained that the changes "more fully [spell] out what constitutes an unfair [insurance] practice" and considerably modernized the existing statutory scheme. Conn. Joint Standing Committee Hearings, Insurance and Real Estate, 1973 Sess., p. 46. Describing the nature of some of the specific revisions, he explained that "unfair claims settlement practices for instance . . . are now spelled out in detail . . . ." Id. Altermatt elaborated that the revised provisions set forth in greater detail "precisely what is an unfair practice and what isn't as regards claims, and claims settlement practices." Id. In discussion on the Senate floor, Senator P. Edmund Power stated that the purpose of the revisions were to "enable the [I]nsurance [C]ommissioner to more effectively carry out his responsibility of protecting our Connecticut citizens." 16 S. Proc., Pt. 3, 1973 Sess., p. 1214. Senator Power's remarks reveal not only that the legislature intended to set out specifically the types of actions that constitute unfair insurance practices in a highly detailed manner, but also that the legislature viewed accomplishing that task as essential to the underlying purpose of CUIPA: enabling the commissioner to better protect consumers. The many subsequent amendments incorporating additional practices as violative of CUIPA demonstrate an ongoing legislative effort to keep the list of prohibited practices as current as possible and provide further evidence of the legislature's intent to provide in CUIPA a comprehensive list of unfair insurance practices. See, e.g., Public Acts 1980, No. 80-259 (adding refusal to insure because of physical disability

or mental retardation); Public Acts 1984, No. 84-189 (adding denial of insurance based on individual's exposure to diethylstilbestrol); Public Acts 1986, No. 86-70 (adding refusal to insure or otherwise discriminating against individual based on blindness); Public Acts 1986, No. 86-407 (adding failure to pay claim within forty-five days of receipt of proof of loss); Public Acts 1995, No. 95-193 (adding refusal to insure individual because individual is victim of family violence); Public Acts 1997, No. 97-95 (refusal to insure individual on basis of genetic information). The legislative history of CUIPA, therefore, demonstrates that the legislature intended to occupy the field of defining unfair insurance practices, thereby precluding courts from incorporating common-law principles as a basis for finding an unfair insurance practice.

Accordingly, we conclude that the common-law principle of fiduciary duty cannot provide the foundation for a CUIPA violation. Section 38a-816 specifically enumerates, in its twenty-two subdivisions, those practices that are defined as unfair insurance practices in this state. None of those subdivisions identifies breach of fiduciary duty as an unfair insurance practice, or otherwise suggests that a breach of fiduciary duty can give rise to an unfair insurance practice. Because there is no statutory basis for concluding that breach of fiduciary duty constitutes a violation of CUIPA, we conclude that the trial court improperly incorporated this common-law concept into its CUIPA analysis by relying on its determination that the defendant had violated the fiduciary duty it owed to its clients to conclude that the defendant violated CUIPA.

II

We next address the defendant's claim that, in the absence of a CUIPA violation, the plaintiff's CUTPA claim must fail. The defendant contends that pursuant to our decision in *Mead* v. *Burns*, supra, 199 Conn. 651, conduct in the insurance industry may constitute a CUTPA violation only if the conduct also violates CUIPA. The plaintiff responds that *Mead* applies only to CUTPA claims that are established through CUIPA, and its CUTPA claim is premised not on a CUIPA violation, but on the plaintiff's violation of the public policy requiring adherence to one's fiduciary duties. We conclude that the plaintiff's CUTPA claim was barred by *Mead* because conduct by an insurance broker or insurance company that is related to the business of providing insurance can violate CUTPA only if it violates CUIPA,[7] and a CUTPA claim in this context cannot be based on breach of a common-law duty.

In *Mead*, the plaintiff claimed that the defendant insurance company had refused in bad faith to settle his claim without conducting a reasonable investigation, in violation of both CUIPA and CUTPA. Id., 653–54. This court concluded that the trial court properly had struck

the plaintiff's CUIPA claim because CUIPA requires "a showing of more than a single act of insurance misconduct." Id., 659. Addressing the question of whether the trial court properly had struck the plaintiff's CUTPA claim, the court observed that General Statutes (Rev. to 1985) § 38-62 (d), which is now § 38a-817 (d), provides: "No order of the commissioner under sections 38-60 to 38-64 [now sections 38a-815 to 38a-819], inclusive, shall relieve or absolve any person affected by such order from any liability under any other laws of this state." (Emphasis omitted; internal quotation marks omitted.) Id., 661. In addition, CUTPA provides: "No person shall engage in . . . unfair or deceptive acts or practices in the conduct of any trade or commerce." General Statutes § 42-110b (a); *Mead* v. *Burns*, supra, 199 Conn. 661–62. Finally, CUTPA provides: "Nothing in this chapter shall apply to: (1) Transactions or actions otherwise permitted under law as administered by any regulatory board or officer acting under statutory authority of the state or of the United States . . . ." General Statutes § 42-110c (a); *Mead* v. *Burns*, supra, 662. This court concluded that, "[i]n combination, these statutory provisions do indicate that the legislature elected to subject insurance practices to multiple rather than to singular regulatory supervision." *Mead* v. *Burns*, supra, 662.

Having concluded that "it is possible to state a cause of action under CUTPA for a violation of CUIPA"; id., 663; this court addressed the following question: "Under what circumstances, if any, may [insurance related] conduct that does *not* violate CUIPA constitute an unfair act or practice under CUTPA?" (Emphasis added.) Id. In support of his claim that "conduct not specifically prohibited by CUIPA may nonetheless offend the public policy of that [act] and therefore may be actionable under CUTPA"; id., 664; the plaintiff relied on this court's decisions in *Conaway* v. *Prestia*, 191 Conn. 484, 464 A.2d 847 (1983), and *Griswold* v. *Union Labor Life Ins. Co.*, 186 Conn. 507, 442 A.2d 920 (1982). *Mead* v. *Burns*, supra, 199 Conn. 662–65. In *Conaway*, the plaintiff tenants claimed that the defendant landlord had violated certain statutes requiring landlords to obtain certificates of occupancy for each rental unit. *Conaway* v. *Prestia*, supra, 486–87. The plaintiffs further claimed that this failure to comply with the statutes violated CUTPA. Id., 487–88. The trial court concluded that the defendant had violated CUTPA by collecting rents from the plaintiffs without having complied with the statutory requirement for certificates of occupancy. Id., 488. On appeal, this court adopted for the first time "the criteria set out in the cigarette rule by the [F]ederal [T]rade [C]ommission for determining when a practice is unfair: (1) [W]hether the practice, without necessarily having been previously considered unlawful, offends public policy as it has been established by statutes, the common law, or otherwise—whether, in other words,

it is within at least the penumbra of some common law, statutory, or other established concept of unfairness; (2) whether it is immoral, unethical, oppressive, or unscrupulous; (3) whether it causes substantial injury to consumers [(competitors or other businessmen)].[8] [Id.], 492–93 . . . ." (Citations omitted; footnote added; internal quotation marks omitted.) *McLaughlin Ford, Inc.* v. *Ford Motor Co.*, 192 Conn. 558, 567–68, 473 A.2d 1185 (1984). This court concluded in *Conaway* that "the defendants' actions of receiving the rent, while not specifically prohibited pursuant to [the relevant housing statutes], unquestionably offended the public policy, as embodied by these statutes, of insuring minimum standards of housing safety and habitability . . . [and] amounted to unfair acts or practices within the meaning of § 42-110b." *Conaway* v. *Prestia*, supra, 493.

In *Griswold* v. *Union Labor Life Ins. Co.*, supra, 186 Conn. 508–509, the plaintiffs brought a claim that the defendant insurance company had refused to pay certain insurance policy benefits to which they were entitled. They further claimed that the defendant's conduct violated both CUTPA and CUIPA. Id., 518–20. The defendant contended that the claim was barred because the plaintiffs had failed to exhaust their administrative remedies under CUIPA. Id., 518. This court concluded that, because the applicable revision of CUIPA did not "authorize the commissioner to award damages to an aggrieved person nor [did] he have the authority to determine a private right to damages . . . the plaintiffs had no practical or adequate administrative remedy which would require exhaustion." Id., 520. Accordingly, this court concluded that the plaintiffs were "entitled to maintain a private right of action for monetary damages [pursuant to § 42-110b] for alleged unfair trade practices, as defined by [CUIPA], without first exhausting the administrative remedies under [CUIPA] . . . ." Id., 520–21.

In *Mead*, this court stated that, "[a]lthough *Conaway* holds that CUTPA may authorize a cause of action that builds upon the public policy embodied in specific statutory provisions, such a CUTPA claim must be consistent with the regulatory principles established by the underlying statutes. In *Griswold*, [this court] held that a litigant complaining of unfair insurance practices was entitled to maintain a private right of action under CUTPA for alleged unfair trade practices, as defined by [CUIPA]. . . . The definition of unacceptable insurer conduct in [CUIPA] reflects the legislative determination that isolated instances of unfair insurance settlement practices are not so violative of the public policy of this state as to warrant statutory intervention. Under CUTPA, as under CUIPA, a litigant is bound by this legislative determination." (Citation omitted; footnote omitted; internal quotation marks omitted.) *Mead* v. *Burns*, supra, 199 Conn. 665–66; see also *Lees* v. *Middlesex Ins. Co.*, 229 Conn. 842, 851, 643 A.2d 1282

(1994) ("[b]ecause the plaintiff's evidence was insufficient to satisfy the requirement under CUIPA that the defendant's alleged unfair claim settlement practices constituted a 'general business practice,' the plaintiff's CUTPA claim could not survive the failure of her CUIPA claim").

Thus, this court in *Mead* and *Lees* clearly held that, if a plaintiff brings a claim pursuant to CUIPA alleging an unfair insurance practice, and the plaintiff further claims that the CUIPA violation constituted a CUTPA violation, the failure of the CUIPA claim is fatal to the CUTPA claim. It is less clear, however, whether *Mead* stands for the proposition that a plaintiff cannot bring a CUTPA claim alleging an unfair insurance practice unless the practice violates CUIPA. The trial courts are split on this issue. Compare *Brico, LLC* v. *Travelers Casualty & Surety Co. of America*, Superior Court, judicial district of Fairfield at Bridgeport, Docket No. CV-09-5023993 (December 29, 2010) (51 Conn. L. Rptr. 161) ("a cause of action under CUTPA could . . . be maintained [only] if the cause of action also satisfied the necessary elements of a CUIPA violation"), and *Newton & Associates, Inc.* v. *Labrasca*, Superior Court, judicial district of Hartford, Docket No. CV-03-0828720S (February 4, 2004) ("[i]t is well settled law in Connecticut that in a CUTPA claim against an insurance company, the plaintiff must allege and prove the CUIPA claim in order to establish a CUTPA claim"), with *Smith* v. *Geico General Ins. Co.*, Superior Court, judicial district of New London, Docket No. CV-08-5006746S (April 7, 2009) ("as long as the allegations under CUTPA are sufficient, the CUTPA count may stand, even if the CUIPA count is stricken" [internal quotation marks omitted]), *Palmieri* v. *Nationwide Mutual Ins. Co.*, Superior Court, judicial district of Fairfield, Docket No. FBT-CV-07-5012326S (January 28, 2009) (same), and *Don Beach Movers, Inc.* v. *Transguard Ins. Co. of America*, Superior Court, judicial district of New London, Docket No. CV-05-4002395 (March 8, 2006) (granting motion to strike CUIPA claim on ground that single instance of unfair insurance practice does not violate statute and denying motion to strike CUTPA claim based on same alleged conduct); see also *Union Street Furniture Carpet, Inc.* v. *Hartford Financial Services Group, Inc.*, Superior Court, judicial district of Stamford-Norwalk, Docket No. FST-CV-04-40002621S (April 12, 2006) (granting motion to strike CUIPA claim on ground that CUIPA provides no private right of action and denying motion to strike CUTPA claim based on same conduct).

The trial court decisions that have concluded that a CUTPA claim based on insurance related conduct can be raised independently of any CUIPA claim can be traced to the decision in *Don Beach Movers, Inc.* v. *Transguard Ins. Co. of America*, supra, Superior Court, Docket No. CV-05-4002395. In turn, the trial court in

that case relied on this court's decision in *Macomber* v. *Travelers Property & Casualty Corp.*, 261 Conn. 620, 804 A.2d 180 (2002). In *Macomber*, this court considered a claim that the defendant insurance companies' conduct in entering into and funding certain structured settlements to settle claims with the plaintiffs violated CUTPA and CUIPA. Id., 642–45. With respect to the CUTPA count, the plaintiffs alleged that the defendants "used and employed unfair and deceptive acts and practices in connection with the solicitation and entering into of structured settlements in connection with the sale of annuities . . . ." (Internal quotation marks omitted.) Id., 643–44. The defendants contended that this allegation was pleaded with insufficient particularity because the allegation did not conform to the cigarette rule. Id., 644. This court was "unpersuaded that there is any special requirement of pleading particularity connected with a CUTPA claim" and, therefore, rejected the defendant's contention. Id. With respect to the CUIPA count, the defendants contended that CUIPA does not provide a private cause of action. Id., 645 n.14. This court concluded that the plaintiffs had alleged that the defendants had violated CUTPA by violating CUIPA and, therefore, there was no need for the court to consider whether CUIPA provides a private cause of action. Id.

In *Don Beach Movers, Inc.* v. *Transguard Ins. Co. of America*, supra, Superior Court, Docket No. CV-05-4002395, the trial court relied on *Macomber* for the proposition that a plaintiff alleging a CUTPA violation is not required to recite the elements of the cigarette rule in order to survive a motion to strike. This court in *Macomber*, however, simply did not address the question of whether a CUTPA claim related to insurance practices can exist independently of a CUIPA violation under *Mead* and *Lees* and, in our view, nothing in this court's reasoning in *Macomber* suggests that it can. Although this court in *Macomber* did not expressly find that the plaintiffs' CUTPA count was based on the alleged CUIPA violation, it observed that the CUTPA count involved "the solicitation and entering into of structured settlements in connection with the sale of annuities"; (internal quotation marks omitted) *Macomber* v. *Travelers Property & Casualty Corp.*, supra, 261 Conn. 643–44; and that the CUIPA count was based on "unfair and deceptive acts and practices in the solicitation of and sale of annuities . . . ." Id., 645. It would appear, therefore, that the alleged CUTPA violation in *Macomber* was based on the alleged CUIPA violation. To the extent that it is unclear whether the CUTPA count was based on the CUIPA count or, instead, was based on separate insurance related conduct, the most that can be said about *Macomber* is that the *Mead/Lees* issue simply was not raised.[9]

The trial courts that have concluded that *Mead* stands for the proposition that a plaintiff must establish a

CUIPA claim in order to establish a CUTPA claim for insurance related business practices have engaged in little analysis of that issue. Nevertheless, we conclude that that determination is supported by *Mead* and by the legislative intent underlying CUIPA. As we previously noted herein, in *Mead*, this court stated that "[t]he definition of unacceptable insurer conduct in [CUIPA] reflects the legislative determination that isolated instances of unfair insurance settlement practices are not so violative of the public policy of this state as to warrant statutory intervention. Under CUTPA, as under CUIPA, a litigant is bound by this legislative determination." (Footnote omitted.) *Mead* v. *Burns*, supra, 199 Conn. 666. Thus, this court strongly suggested that the legislative determinations as to unfair insurance practices embodied in CUIPA are the exclusive and comprehensive source of public policy in this area.

Moreover, it would be difficult to reconcile the court's conclusion in *Mead* v. *Burns*, supra, 199 Conn. 665–66, that a CUTPA claim that is based on a *colorable* CUIPA claim cannot survive the demise of the CUIPA claim with a conclusion that a plaintiff can raise a CUTPA claim that is based on insurance related conduct that does not even arguably come within the scope of CUIPA. In other words, if a plaintiff cannot claim that an insurance company violated public policy and, therefore, violated CUTPA, by refusing to pay a single insurance claim without conducting a reasonable investigation, even though the legislature has clearly expressed disapproval of such conduct in § 38a-816 (6) (D), we see no reason why an allegation of a specific type of insurance related conduct that the legislature has expressed no opinion about should be found to support a CUTPA claim.[10]

Finally, we concluded in part I of this opinion that the legislative history of CUIPA reveals that "the legislature intended to set out specifically the types of actions that constitute unfair insurance practices in a highly detailed manner . . . [and] viewed accomplishing that task as essential to the underlying purpose of CUIPA: enabling the commissioner to better protect consumers. The many subsequent amendments incorporating additional practices as violative of CUIPA demonstrate an ongoing legislative effort to keep the list of prohibited practices as current as possible and provide further evidence of the legislature's intent to provide in CUIPA a *comprehensive* list of unfair insurance practices. . . . The legislative history of CUIPA, therefore, demonstrates that *the legislature intended to occupy the field of defining unfair insurance practices*, thereby precluding courts from incorporating common-law principles as a basis for finding an unfair insurance practice." (Citations omitted; emphasis added.)

Under the first prong of the cigarette rule, whether a business practice violates CUTPA depends on

whether the practice, "without necessarily having been previously considered unlawful, offends public policy as it has been established by statutes, the common law, or otherwise—whether, in other words, it is within at least the penumbra of some common-law, statutory, or other established concept of unfairness . . . ." (Internal quotation marks omitted.) *McLaughlin Ford, Inc.* v. *Ford Motor Co.*, supra, 192 Conn. 568. Because CUIPA provides the exclusive and comprehensive source of public policy with respect to general insurance practices, we conclude that, unless an insurance related practice violates CUIPA or, arguably, some other statute regulating a specific type of insurance related conduct, it cannot be found to violate any public policy and, therefore, it cannot be found to violate CUTPA.

More specifically, with respect to the question of whether an insurance entity's breach of its fiduciary duty violates CUTPA, we note that an insurer generally has a fiduciary relationship with its insured. See *Hutchinson* v. *Farm Family Casualty Ins. Co.*, 273 Conn. 33, 53, 867 A.2d 1 (2005) (*Norcott, J.*, dissenting) ("American jurisprudence . . . has long recognized that an insurer and its insured have a special relationship . . . that is characterized by elements of public interest, adhesion and fiduciary responsibility" [citations omitted; internal quotation marks omitted]). Accordingly, many of the unfair practices described in CUIPA, such as the refusal to pay a valid insurance claim under § 38a-816 (6) (D), could be characterized as a breach of fiduciary duty. Nevertheless, this court held in *Mead* that, because a single failure to pay a valid insurance claim in violation of § 38a-816 (6) (D) does not violate CUIPA, it does not violate CUTPA. Accordingly, we conclude that a common-law breach of fiduciary duty arising in the insurance context that does not violate CUIPA or some other statute regulating the insurance industry cannot provide the basis for a valid CUTPA claim.

The judgment is reversed and the case is remanded to the trial court with direction to render judgment for the defendant.

In this opinion the other justices concurred.

* The listing of justices reflects their seniority status on this court as of the date of oral argument.

[1] The defendant appealed from the judgment of the trial court to the Appellate Court and we transferred the appeal to this court pursuant to General Statutes § 51-199 (c) and Practice Book § 65-1.

[2] General Statutes § 38a-816 provides: "The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

"(1) Misrepresentations and false advertising of insurance policies. Making, issuing or circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison which: (A) Misrepresents the benefits, advantages, conditions or terms of any insurance policy; (B) misrepresents the dividends or share of the surplus to be received, on any insurance policy; (C) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; (D) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system

upon which any life insurer operates; (E) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; (F) is a misrepresentation, including, but not limited to, an intentional misquote of a premium rate, for the purpose of inducing or tending to induce to the purchase, lapse, forfeiture, exchange, conversion or surrender of any insurance policy; (G) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or (H) misrepresents any insurance policy as being shares of stock.

"(2) False information and advertising generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, 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 his insurance business, which is untrue, deceptive or misleading.

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

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

"(5) False financial statements. Filing with any supervisory or other public official, or making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive; or making 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, wilfully omitting 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.

"(6) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following: (A) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; (B) failing to acknowledge and act with reasonable promptness upon communications with respect to claims arising under insurance policies; (C) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; (D) refusing to pay claims without conducting a reasonable investigation based upon all available information; (E) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed; (F) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear; (G) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds; (H) attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application; (I) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured; (J) making claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made; (K) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration; (L) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information; (M)

failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; (N) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; (O) using as a basis for cash settlement with a first party automobile insurance claimant an amount which is less than the amount which the insurer would pay if repairs were made unless such amount is agreed to by the insured or provided for by the insurance policy.

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

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

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

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

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

"(B) (i) Subparagraph (A)(iii) of this subdivision shall not include the interest which may be charged on premium loans or premium advancements in accordance with the security instrument. (ii) For purposes of subparagraph (A)(ii) of this subdivision, such disapproval shall be deemed unreasonable if it is not based solely on reasonable standards uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for the disapproval of

an insurance policy because such policy contains coverage in addition to that required. (iii) The commissioner may investigate the affairs of any person to whom this subdivision applies to determine whether such person has violated this subdivision. If a violation of this subdivision is found, the person in violation shall be subject to the same procedures and penalties as are applicable to other provisions of section 38a-815, subsections (b) and (e) of section 38a-817 and this section. (iv) For purposes of this section, 'person' includes any individual, corporation, limited liability company, association, partnership or other legal entity.

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

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

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

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

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

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

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

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

"(16) Failure to pay, as part of any claim for a damaged motor vehicle under any automobile insurance policy where the vehicle has been declared to be a constructive total loss, an amount equal to the sum of (A) the settlement amount on such vehicle plus, whenever the insurer takes title to such vehicle, (B) an amount determined by multiplying such settlement amount by a percentage equivalent to the current sales tax rate established in section 12-408. For purposes of this subdivision, 'constructive total loss' means the cost to repair or salvage damaged property, or the cost to both repair and salvage such property, equals or exceeds the total value of the property at the time of the loss.

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

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

"(19) With respect to an insurance company, hospital service corporation, health care center or fraternal benefit society providing individual or group health insurance coverage of the types specified in subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of genetic information. Genetic information indicating a predisposition to a disease or condition shall not be deemed a preexisting condition in the absence of a diagnosis of such disease or condition that is based on other medical information. An insurance company, hospital service corporation, health care center or fraternal benefit society providing individual health coverage of the types specified in subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, shall not be prohibited from refusing to insure or applying a preexisting condition limitation, to the extent permitted by law, to an individual who has been diagnosed with a disease or condition based on medical information other than genetic information and has exhibited symptoms of such disease or condition. For the purposes of this subsection, 'genetic information' means the information about genes, gene products or inherited characteristics that may derive from an individual or family member.

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

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

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

Although the defendant's alleged violations occurred during 1999 through 2002, for purposes of convenience and clarity, we refer herein to the current revision of § 38a-816. Many of the changes that occurred both during the

relevant three year period and subsequent thereto are technical in nature, and none of the changes affect the present appeal.

[3] Because we conclude that the trial court improperly determined that the state had proven a CUIPA violation and that under the facts of the present case, the CUTPA claim must fail due to the failure of the CUIPA claim, it is unnecessary for us to address the defendant's remaining claims on appeal. Specifically, the defendant claims that the trial court's factual findings were inconsistent with its conclusion that the defendant's actions were deceptive or misleading in violation of CUIPA. The defendant also claims that the trial court improperly: (1) concluded that the defendant had a fiduciary duty to disclose the contingent commissions to clients despite the lack of a statutory requirement that producers disclose insurer provided commissions, the absence of a custom or practice of such disclosure in the insurance industry during the relevant time period or even today, and the dictates of corporate law that parent corporations and their subsidiaries must be treated as separate and distinct legal persons; (2) concluded that the program created a conflict of interest, despite its factual findings that producers acted in the clients' best interests and that the clients sustained no damage; and (3) ordered class based relief in the form of an accounting for each and every one of the defendant's Connecticut clients, where the defendant argues that the state did not bring this action as a class action and damages are barred by the "filed rate doctrine."

[4] The plaintiff claims in this court that because it brought this action pursuant to § 42-110m, it was not required to prove harm. The defendant had raised this issue in the trial court by filing a motion to strike the complaint on the basis that the plaintiff had failed to allege that the defendant's conduct caused injury to consumers. The trial court, *Shortall*, *J.*, denied the motion to strike, observing that the state brought this action under § 42-110m (a), which does not require proof of ascertainable loss.

It is not necessary for us to address the plaintiff's claim. The defendant does not challenge the trial court's denial of its motion to strike on this basis. Moreover, although the trial court, *Dubay*, *J.*, ultimately found that the plaintiff had failed to prove that individual consumers were harmed by the defendant's conduct, that finding does not appear to have played a part in its analysis of the plaintiff's claims, as the court rendered judgment in favor of the plaintiff notwithstanding that finding. Finally, our conclusion that the defendant did not violate either CUIPA or CUTPA renders moot the question of whether the plaintiff was required to prove harm.

[5] General Statutes § 42-110m (a) provides in relevant part: "Whenever the [C]ommissioner [of Consumer Protection] has reason to believe that any person has been engaged or is engaged in an alleged violation of any provision of this chapter said commissioner may . . . request the Attorney General to apply in the name of the state of Connecticut to the Superior Court for an order temporarily or permanently restraining and enjoining the continuance of such act or acts or for an order directing restitution and the appointment of a receiver in appropriate instances or both. Proof of public interest or public injury shall not be required in any action brought pursuant to . . . this section. The court may award the relief applied for or so much as it may deem proper including reasonable attorney's fees, accounting and such other relief as may be granted in equity. . . ."

[6] The plaintiff's single count revised complaint alleged that the defendant's actions violated both CUTPA and CUIPA. The plaintiff's prayer for relief sought a finding that the defendant had violated CUTPA, injunctive relief enjoining the defendant from engaging in any further such conduct in violation of CUTPA, an order requiring the defendant to submit to an accounting, civil penalties, an order directing the defendant to pay restitution, an order directing the defendant to disclose all revenues, profits and gains achieved in whole or in part through the defendant's unfair practices, and costs and attorney's fees.

[7] The question of "whether a business transaction by a commercial entity must be in the conduct of that entity's main business to be in the conduct of trade or commerce for purposes of CUTPA . . . has not been addressed by an appellate court in Connecticut." (Footnote omitted.) R. Langer et al., 12 Connecticut Practice Series: Unfair Trade Practices (2003) § 3.2, p. 63. We need not decide this issue in the present case, however, because although the plaintiff contends that breach of fiduciary duty is not unique to the insurance business, there is no dispute that the conduct at issue was related to the defendant's insurance business. Accordingly, the sole question before us is whether conduct by an insurance company that is related to its insurance business can be found to violate CUTPA when it does not violate CUIPA.

[8] "Although we consistently have followed the cigarette rule in CUTPA cases, we also note that, when interpreting 'unfairness' under CUTPA, our decisions are to be guided by the interpretations of the Federal Trade Act by the Federal Trade Commission and the federal courts. See General Statutes § 42-110b [b]. Review of those authorities indicates that a serious question exists as to whether the cigarette rule remains the guiding rule utilized under federal law. See *American Financial Services Assn.* v. *Federal Trade Commission*, 767 F.2d 957, 969–70 (D.C. Cir. 1985), cert. denied, 475 U.S. 1011, 106 S. Ct. 1185, 89 L. Ed. 2d 301 (1986); see also P. Sobel, 'Unfair Acts or Practices Under CUTPA,' 77 Conn. B.J. 105 (2003). Because . . . neither party has raised or briefed this issue, and both have briefed the issue applying the cigarette rule, we decline to address the issue of the viability of the cigarette rule until it squarely has been presented to us. See *American Car Rental, Inc.* v. *Commissioner of Consumer Protection*, 273 Conn. 296, 305 n.6, 869 A.2d 1198 (2005)." *Glazer* v. *Dress Barn, Inc.*, 274 Conn. 33, 82 n.34, 873 A.2d 929 (2005).

[9] One authority has suggested that, if insurance related conduct violates a *statute* other than CUIPA, the conduct can be the subject of a CUTPA claim. See R. Langer et al., 12 Connecticut Practice Series: Unfair Trade Practices (2003) § 3.15, p. 133 ("[a] significant limitation of the *Mead* requirement of a general business practice for establishing a CUIPA violation is that the statutory limitation is not applicable to all CUIPA provisions *or an insurance-related action that violates a different statutory provision outside of CUIPA*" [emphasis added]). The authors of that Connecticut Practice Series cite *Lenz* v. *CNA Assurance Co. of Connecticut*, Superior Court, judicial district of Ansonia-Milford, Docket No. CV-89-028737S (February 24, 1992), in support of this proposition. In *Lenz*, the plaintiff claimed that the defendant insurance company, which was his employer's workers' compensation carrier, violated CUTPA when it discontinued his workers' compensation payments in violation of General Statutes § 31-296a. The defendant claimed that the plaintiff's claim was barred by *Mead* because he made no claim that the defendant had violated CUIPA. Citing this court's decision in *Conaway* v. *Prestia*, supra, 191 Conn. 484, for the proposition that "CUTPA may authorize a cause of action that builds upon the public policy embodied in specific statutory provisions"; *Mead* v. *Burns*, supra, 199 Conn. 665; the trial court in *Lenz* concluded that the plaintiff's allegation that the defendant had violated § 31-296a supported his CUTPA claim.

It is arguable, however, that *Lenz* was incorrectly decided and that the plaintiff's claim in that case was barred by *Mead* because § 38a-816 (6) prohibits unfair claim settlement practices, including the refusal "to pay claims without conducting a reasonable investigation based upon all available information"; General Statutes § 38a-816 (6) (D); only when committed "with such frequency as to indicate a general business practice"; General Statutes § 38a-816 (6); and the plaintiff in *Lenz*, as in *Mead*, had alleged just a single instance of an unfair practice. It is difficult to see why, if a single unjustified refusal to pay a property damage claim does not violate public policy, a single unjustified refusal to pay a workers' compensation claim does violate public policy. We need not resolve this issue, however, in the present case. Although the plaintiff suggests in its brief to this court that the defendant's conduct was in violation of General Statutes § 53a-161, which prohibits a fiduciary from receiving a benefit from a person other than the principal upon the understanding that the benefit will influence the fiduciary's conduct toward the principal, it did not raise this claim in the trial court and, therefore, it is not preserved for review.

[10] Accordingly, we are not persuaded by the plaintiff's argument that "requiring that all insurance related CUTPA claims be circumscribed by CUIPA contravenes CUTPA's liberal construction and remedial purpose." Although the plaintiff is correct that CUTPA is liberally construed; *Fink* v. *Golenbock*, 238 Conn. 183, 213, 680 A.2d 1243 (1996); and that the legislature "deliberately chose not to define the scope of unfair or deceptive acts proscribed by CUTPA so that courts might develop a body of law responsive to the marketplace practices that actually generate such complaints"; *Sportsmen's Boating Corp.* v. *Hensley*, 192 Conn. 747, 755, 474 A.2d 780 (1984); this argument amounts to a claim that *Mead* should be overruled.