INSURANCE LAW IN THE UNITED STATES (VERMONT)

Emphasis – Automobile Insurance

Sponsored By: Supreme Arbitrazh Court, Republic of Karelia
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Mark D. Oettinger
General Counsel, Vermont Department of Education

Harland L. Miller, III
Vice President and Vermont State Counsel, First American Title Insurance Company

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SELECTED VERMONT AUTOMOBILE INSURANCE STATUTES

23 VSA § 800. Maintenance of financial responsibility

(a) No owner or operator of a motor vehicle required to be licensed shall operate or permit the operation of the vehicle upon the highways of the state without having in effect an automobile liability policy or bond in the amounts of at least $25,000.00 for one person and $50,000.00 for two or more persons killed or injured and $10,000.00 for damages to property in any one accident. In lieu thereof, evidence of self-insurance in the amount of $115,000.00 must be filed with the commissioner of motor vehicles. Such financial responsibility shall be maintained and evidenced in a form prescribed by the commissioner. The commissioner may require that evidence of financial responsibility be produced before motor vehicle inspections are performed pursuant to the requirements of section 1222 of this title.

(b) A person who violates this section shall be assessed a civil penalty of not more than $100.00, and such violation shall be a traffic violation within the meaning of chapter 24 of this title.

23 VSA § 801. Proof of financial responsibility required

(a) The commissioner shall require proof of financial responsibility to satisfy any claim for damages, by reason of personal injury to or the death of any person, of at least $25,000.00 for one person and $50,000.00 for two or more persons killed or injured and $10,000.00 for damages to property in any one accident, as follows:

(1) From a person who is convicted of any of the following violations of this title:

(A) Death resulting from:

(i) Careless and negligent operation of a motor vehicle; or

(ii) Reckless driving of a motor vehicle.

(B) Any violation of section 1201 [Driving under the influence of alcohol or drugs] of this title or for any suspension pursuant to section 1205 of this title;

(C) Failing to immediately stop and render such assistance as may be reasonably necessary following an accident resulting in injury to any person or property, other than the vehicle then under his or her control;

(D) Operating, taking, using, or removing a motor vehicle without the consent of the owner in violation of section 1094 of this title;

(E) Operating a motor vehicle after suspension, revocation, or refusal of a license, in violation of section 674 of this title;

(F) Operating without financial responsibility;

(G) Any moving violation as defined in section 4 of this title if the person has five points assessed against the person's license at the time the moving violation occurs.

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(2) From a person against whom there is an outstanding unsatisfied judgment of a court of competent jurisdiction within this state for damages arising out of a motor vehicle accident and based upon any violation of the provisions of this title.

(3) From the operator of a motor vehicle involved in an accident which has resulted in bodily injury or death to any person or whereby the motor vehicle then under his or her control or any other property is damaged in an aggregate amount to the extent of $1,000.00 or more.

(c) In lieu of the insurance policy or surety bond required under this section, a person may qualify as a self-insurer by obtaining a certificate of self-insurance from the commissioner, who may, in his or her discretion, upon the application of such person, issue said certificate of self-insurance, when he or she is satisfied that such person is possessed of a net unencumbered capital of at least $115,000.00.

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8 VSA § 802. Suspension of license

(a) Proof of financial responsibility shall cover a person in the operation of any and all motor vehicles operated by him or her. If he or she fails to furnish such proof, when required under the provisions of section 801 of this title, within 20 days after notice from the commissioner is mailed to him or her, until such proof is furnished, the commissioner shall suspend the license of an operator or the right of an unlicensed operator, or nonresident to operate any motor vehicle in this state.

* * *

8 VSA § 941. Insurance against uninsured motorists

(a) No policy insuring against liability arising out of the ownership, maintenance or use of any motor vehicle may be delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state unless coverage is

provided therein, or supplemental thereto, for the protection of persons insured thereunder who are legally entitled to recover damages, from owners or operators of uninsured, underinsured or hit-and-run motor vehicles, for bodily injury, sickness or disease, including death, and for property damages resulting from the ownership, maintenance or use of such uninsured, underinsured or hit-and-run motor vehicle. The coverage for property damages shall be sufficient to indemnify a claim for damages to which the claimant is legally entitled of no more than $10,000.00 per claim, subject to a $150.00 deductible;

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(e) If payment is made under uninsured motorist coverage, and subject to the terms of that coverage, to the extent of that payment, the insurer is entitled to the proceeds of any settlement or recovery from any person legally responsible for the damage or personal injury, as to which the payment was made, and to amounts recoverable from the assets of an insolvent insurer of such person. However, if the injured party settles or recovers against any person, any reimbursement due to an insurer under this section shall be reduced by deducting a fair portion of all reasonable expenses of recovery incurred in effecting the settlement or recovery. The expenses of recovery shall be apportioned between the parties as their interests appear at the time of the settlement or recovery.

(f) For the purpose of this subchapter, a motor vehicle is underinsured to the extent that:

(1) the liability insurance limits applicable at the time of the accident are less than the limits of the uninsured motorist coverage applicable to the insured; or

(2) the available liability insurance has been reduced by payments to others injured in the accident to an amount less than the limits of the uninsured motorist coverage applicable to the insured.

UNITED STATES INSURANCE LAW
GENERAL FEDERALISM CONSIDERATIONS

Most laws regulating the insurance industry in the United States are state-specific. In 1869, a decision of the United States Supreme Court held, in *Paul v. Virginia*, 75 U.S. 168, that the United States Congress did not have the authority, under its general authority to regulate commerce, to regulate insurance.

In the 1930s and 1940s, a number of United States Supreme Court decisions broadened the interpretation of the United States Constitution's "Commerce Clause" in various ways, so that federal jurisdiction over interstate commerce could be seen as extending to insurance. In 1948, however, the United States Congress expressly reaffirmed its support for state-based insurance regulation by passing the McCarran-Ferguson Act (15 United States Code §§ 1011-15) which mandated that no law that Congress may pass shall be construed to invalidate, impair or supersede any law regarding insurance which has been, or which may be, enacted by a State. As a result, nearly all regulation of insurance continues to take place at the state level.

SELECTED VERMONT INSURANCE REGULATIONS

8 VSA § 4723. Unfair methods of competition or unfair or deceptive acts or practices prohibited

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

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

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

* * *

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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8 VSA § 4726. Power of commissioner; enforcement

(a) The commissioner shall have the power to examine and investigate any person engaged in the business of insurance in this state in order to determine whether that person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice.

(b) Any person violating any of the provisions of this chapter may be subject to an administrative penalty of not more than $1,000.00 for each violation. The commissioner may impose an administrative penalty of not more than $10,000.00 each for those violations the commissioner finds were willful. The commissioner may suspend or

revoke the license of any insurer or organization for any violation of this chapter or the failure to comply with an order of the commissioner issued under this chapter.

THE PRINCIPLE OF "BAD FAITH"

An insurance company has many duties to its policyholders. Those duties vary depending upon whether the claim is considered to be a "first party" claim or a "third party" claim. An example of a first party claim is one in which a person insures property that becomes damaged, such as a house or an automobile. In that case, the insurance carrier is required to investigate the damage, determine whether the damage is covered, and if it is covered, pay the proper value for the damaged property. Bad faith in the first party context often involves the insurance carrier's improper investigation and valuation of the damaged property.

Bad faith in the third party context, however, breaks down into two distinct duties. First, the insurance carrier usually has a duty to defend a claim, or the lawsuit, even if some or most of the lawsuit is not covered by the insurance policy. Second, the insurance carrier has a duty of "indemnification," which is the duty to pay a judgment which is rendered against the policyholder, up to the limits of the policy's coverage, but only if the judgment is for a covered act or omission. As a result, most insurance companies exercise a great deal of control over litigation. Bad faith can occur in either situation: by improperly refusing to defend a lawsuit; or by improperly refusing to pay a judgment or settlement which arises out of a covered lawsuit.

Bad faith is not an easily defined concept, and is defined primarily by court decisions in case law. Examples of bad faith include undue delay in handling claims, inadequate investigation, refusal to defend a lawsuit, threats against an insured, refusing to make a reasonable settlement offer, and making unreasonable interpretations of an insurance policy. Following an act of bad faith by the insurance carrier, the policyholder may recover damages if, for example, the insurance carrier refuses to make a reasonable settlement offer which the policyholder wants, and if the policyholder, as a result, is later subject to a judgment in excess of the policy limits.

In some cases, the state's case law regarding "torts" (civil wrongs), or an applicable state statute, may allow for the imposition of "punitive" damages (meaning damages beyond those actually suffered by the policy holder as a result of the bad faith) against insurance carrier. The policy behind such punitive damages is to punish the insurance carrier, and to dissuade it, and other insurance carriers, from engaging in such bad faith in the future.

SUBROGATION

The right of subrogation is an insurance company's right to seek reimbursement from a person or entity who is legally responsible for an accident after the insurer has paid out money on behalf of its insured. The general rule is that, after paying the claim, the insurer is "subrogated" to the rights of the insured and can "step into the shoes" of the insured to go after or sue the negligent party on the insured's behalf. Not all insurers subrogate for medical bills. When they do, the right of subrogation may be against the other driver's insurance, or it may be against the insured's own separate health insurance policy, or against any other medical insurance that would cover the insured's treatment.

Subrogation may also be employed when the insurer settles a collision claim for damage to the insured's vehicle due to another driver's negligence. Generally, the insurer will have the insured sign a subrogation release which assigns the insured's right of recovery against the person who is responsible for the loss to the insurer. Insurers may not delay the settlement of the claim until they get paid from the person who was at fault. Subrogation usually occurs some time after the original claim is settled. Some insurers will include the deductible when they subrogate, and the insured will get the deductible back when the other driver or another insurance company of the insured pays the subrogation claim.

VERMONT STATUTE PROHIBITING INSURANCE FRAUD

8 VSA § 4750. Insurer anti-fraud plans

(a) Every insurer with direct written premiums shall prepare, implement, and maintain an insurance anti-fraud plan. Each insurer's anti-fraud plan shall outline specific procedures, appropriate to the type of insurance the insurer writes in this state, to:

(1) Prevent, detect, and investigate all forms of insurance fraud, including fraud involving the insurer's employees or agents; fraud resulting from misrepresentations in the application, renewal, or rating of insurance policies; claims fraud; and security of the insurer's data processing systems.

(2) Educate appropriate employees on fraud detection and the insurer's anti-fraud plan.

(3) Provide for the hiring of or contracting for fraud investigators.

(4) Report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud.

(5) Where appropriate, pursue restitution for financial loss caused by insurance fraud.

(6) Ensure that applicable state and federal privacy laws are complied with and that the confidential personal and financial information of consumers and insureds is protected.

(7) Comply with such other procedures as the commissioner may require by rule.

(b) The commissioner may require an insurer to file annually its anti-fraud plan with the department and an annual summary of the insurer's anti-fraud activities and results, including misclassification and miscoding. A workers' compensation insurer shall file an anti-fraud plan with the department of labor, including information about fraud investigations, referrals, or prosecutions involving Vermont workers' compensation claims, misclassifications, and miscoding, if requested by the commissioner of labor. Information regarding fraud investigations and referrals shall not be public unless the commissioner of labor or the attorney general commences administrative or criminal proceedings. For purposes of this subsection:

(1) "Misclassification" means improperly classifying employees as independent contractors for the purposes of workers' compensation insurance or unemployment insurance, as the context dictates.

(2) "Miscoding" means the improper categorization of employees under the National Council on Compensation Insurance (NCCI) worker classification codes, which account

for varying levels of risk attributable to different job types for the purposes of determining workers' compensation insurance premiums.

(c) This section confers no private rights of action. This section does not affect private rights of action conferred under other laws or court decisions.

(d) Enforcement. Notwithstanding any other provision of this title, the following are the exclusive monetary penalties for violation of this section. Insurers that fail to prepare, implement, maintain, or submit to the department of banking, insurance, securities, and health care administration an insurance anti-fraud plan are subject to a penalty of $500.00 per day, not to exceed $10,000.00.

THE INSURED'S DUTY TO COOPERATE

A liability policy typically requires the insured to cooperate with the insurer. Under that provision, the insured must, among other things, cooperate with the insurer in investigating and/or settling the claim. Breach of the cooperation clause by the insured relieves the insurer of liability under the policy, but the insurer must show that the breach caused "substantial prejudice." Furthermore, prejudice to the insurer is not presumed as a matter of law from the insured's breach. Instead, the insurer "shoulders a heavy burden" to establish that the insured acted willfully to obstruct the insurer.

FACT PATTERN

In the course of her employment, an Employee (who was a nurse) was driving to see a medical patient in the patient's home, when she struck an oncoming car, killing the driver (the Deceased). The Employee had her own $20,000 personal automobile insurance policy, which promptly paid the full $20,000 limits of that policy to the Estate of the Deceased. The Estate then demanded further compensation for the death of the Deceased from the Employer. At the time of the accident, the Employer had an automobile insurance policy with an insurance company (the Insurer) which denied coverage and refused to defend or indemnify the Employer.

The Estate sued the Employer for damages arising out of the wrongful death of the Deceased. The Employer, who had essentially no assets, again asked the Insurer to defend and indemnify, and the Insurer again denied coverage. Thereafter, the Estate and the Employer entered into a settlement agreement of their lawsuit which provided for a stipulated judgment in the amount of $2,000,000, but which delayed enforcement of the judgment against assets of the Employer pending litigation against the (different) insurance company through which the Deceased had had uninsured/underinsured coverage under his own automobile insurance policy.

The Deceased's uninsured/underinsured policy had a limit of $500,000. The litigation which was instituted by the Estate of the Deceased against the insurance company which had provided the Deceased's uninsured/underinsured motorist coverage resulted in a settlement of $425,000. Having paid this amount to settle the claim of the Estate, the insurance company which had provided the Deceased's uninsured/underinsured motorist coverage brought suit against the Employer for return of the $425,000 under the principle of subrogation.

EDITED EXCERPTS FROM THE VERMONT SUPREME COUT DECISION REGARDING ABOVE FACT PATTERN

The uninsured/underinsured carrier's limited right of subrogation is created by statute, as follows: "If payment is made under uninsured motorist coverage...to the extent of

that payment, the insurer is entitled to the proceeds of any...recovery from any person legally responsible for the damage or personal injury..." 23 V.S.A. § 941(e). It is limited because the carrier can obtain reimbursement only after the injured party is fully compensated.

An uninsured/underinsured carrier is therefore entitled to reimbursement for payment it makes to an accident victim to the extent the victim's total recovery from all sources exceeds his or her damages. The carrier is entitled to no reduction of uninsured/underinsured coverage, however, where the victim is not fully compensated.

Subrogation is the substitution of a person for a creditor to whose rights the substitute succeeds in relation to the debt, and it gives the creditor all the rights, priorities, remedies, liens, and securities of the person for whom he or she is substituted. Subrogation enables a secondarily liable party who has been compelled to pay a debt to be made whole by collecting that debt from the primarily liable party, who, in good conscience, should be required to pay. The purpose of subrogation is purely equitable.

On the basis of these facts and these principles of subrogation law, the court found in favor of the uninsured/underinsured carrier, and ruled that it was entitled to be reimbursed by the Employer (and since the employer was judgment proof, by the Employer's liability Insurance carrier) for the amount which it had been forced to pay to the estate.

Note: In an attempt to provide an understandable illustration of the principles of subrogation, the facts of a rather complex 2005 Vermont Supreme Court case have been simplified, and the actual language of the decision has been paraphrased. The authors wish to express their thanks and their apologies to John Dooley, the author of that decision.