

DEFENDING CLAIMS OF INSURANCE BAD FAITH

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I. TEN MOST CRUCIAL RULES IN BAD FAITH LITIGATION

A. *Simply proving that insurer failed to timely pay a claim is insufficient for plaintiff to recover bad faith penalties or damages.*

- Reed v. State Farm Auto. Ins. Co., 857 So.2d 1012 (La. 10/21/03)

Insured, who was injured in a traffic accident, brought action against UM insurer, alleging insurer acted arbitrarily and capriciously in failing to timely tender payment under the policy. The court stated that where the extent of plaintiff's damages was the center of dispute, especially the timing of and need for a total knee replacement, the existence of facts such as a previous accident with injury to the same knee can be the basis for reasonable doubt on the insurer's part as to plaintiff's entitlement to the policy limits. The court held that sanctions of penalties and attorney fees should not be assessed unless plaintiff's proof is clear that the insurer was in fact arbitrary, capricious, or without probable cause in refusing to pay the claim. Especially when there is a reasonable and legitimate question as to the extent and causation of the claim, bad faith should not be inferred from the insurer's failure to timely pay insured's claim.

- Clark v. Clarendon Ins. Co., 841 So.2d 1039 (La.App. 3rd Cir. 3/26/03)

Insured filed suit against his commercial auto insurance carrier for failure to pay costs associated with his damaged truck after it was allegedly stolen. The insurer refused to pay the plaintiff's claim based on its belief that the policy was cancelled prior to the truck being stolen. Finding the insurer not to be in bad faith, the court

stated that an insurer's action is arbitrary and capricious only when its willful refusal of a claim is not based on a good faith defense or is unreasonable or without probable cause.

- Maurice v. Prudential Ins. Co., 831 So.2d 381 (La.App. 4th Cir. 10/23/02)

Insured brought action against insurer seeking coverage under homeowner's policy for damages to his home resulting from hailstorm and for bad faith damages, penalties, and attorney fees for failing to promptly pay the claim. There was a factual dispute as to whether the roof damage was actually caused by the hailstorm. The court held that statutory bad faith penalties are inappropriate when the insurer has a reasonable basis to defend the claim and was acting in good faith reliance on that defense.

- Coker v. Morris, 855 So.2d 916 (La.App. 2nd Cir. 9/24/03)

Homeowners brought a negligence action against their neighbors and the parents of a child who was visiting the neighbors, alleging that the child started a fire that destroyed their home, barn, and fields. Although the plaintiffs filed suit timely, they failed to timely serve one of the defendants within the requisite 90-day period. In fact, they did not request service for almost ten months. Plaintiffs suggested that their failure to request service timely may not have been diligent, but was not in bad faith. Under La.R.S. 9:5801, a plaintiff's suit can be dismissed for prescription if the reason they have failed to serve a defendant within the requisite 90 days is because of "bad faith" on the part of the plaintiff. The issue in this case was whether the plaintiffs' claim against this one defendant should be dismissed via prescription because of their failure to timely serve the him. That issue, in turn, required a finding of "good faith" or "bad faith". The trial court dismissed the claim. The Second Circuit reversed. In defining "bad faith", the Second Circuit stated that "bad faith means more than mere bad judgment or negligence; it implies the conscious doing of wrong for dishonest or morally questionable motives."

B. *Whether an insurer is in bad faith depends on facts known to the insurer at the time of the refusal to pay.*

- Sutton v. Oncale, 765 So.2d 1072 (La.App. 5th Cir. 3/29/00)

An automobile accident victim brought action against tort-feasor, his liability insurer, and UM carrier. Victim settled the tort claim and sought penalties from the UM carrier for bad faith due to the carrier's failure to tender payments under the policy. "Whether a refusal to pay a claim is arbitrary, capricious, or without probable cause hinges on the facts known to the insurer at the time of its refusal to pay the claim." The court held that, based on the lack of medical evidence/facts known by the insurer at the time of its evaluation, the UM insurer did not act in bad faith by refusing to offer a settlement.

- Genusa v. Robert, 720 So.2d 166 (La.App. 5th Cir. 10/14/98)

Insured brought action to recover UM benefits and bad faith damages for insurer's failure to tender a reasonable payment under the policy. "Whether a refusal to pay a claim is arbitrary, capricious, or without probable cause hinges on the facts known to the insurer at the time of its refusal to pay the claim." The evidence submitted by plaintiffs showed that the insurer was aware of the extent of plaintiff's injuries at the time that it refused to tender payment. The insurer was found to be arbitrary and capricious in their refusal to make a good faith tender.

- Reed v. State Farm Auto Ins. Co., 857 So.2d 1012 (La. 10/21/03)

UM carrier was not in bad faith for refusing to tender policy limits because at the time of refusal, plaintiff had not provided insurer with a satisfactory proof of loss. "Whether or not insurer's refusal to pay insured's claim is arbitrary, capricious or without probable cause, is a factual issue depending on the facts known to the insurer at the time of its action."

C. *Plaintiff must have a valid underlying claim.*

- Fleming v. American Auto. Association, 764 So.2d 274 (La.App. 4th Cir. 6/21/00)

A tourist brought an action against her travel insurer, the policy administrator, the medical assistance contractor, and the wholesale tour provider to recover damages for her injuries resulting from a faulty medical evacuation and also for bad faith damages for breaching the duty of good faith and fair dealing under La. R.S. 22:1220. The court dismissed the bad faith claims because the plaintiff failed to establish a valid underlying claim. “To successfully assert a claim against an insurer for breaching its duty to adjust claims fairly and promptly and to make reasonable settlement efforts, plaintiff must first have a valid, substantive claim for which insurance coverage is due.

- Phillips v. Patterson Ins. Co., 813 So.2d 1191 (La.App. 3rd Cir. 4/3/02)

Plaintiff filed suit for injuries arising out of an auto accident, naming the driver and his liability insurer. In addition plaintiff sought bad faith damages from the insurer due to its failure to timely tender a settlement. The plaintiff’s underlying damages claim was dismissed via an exception of prescription. The court concluded that a plaintiff attempting to base her theory of recovery against an insurer for bad faith damages must first have a valid underlying, substantive claim upon which insurance coverage is based. “The penalties authorized by 22:658 and 22:1220 do not stand alone; they do not provide a cause of action against an insurer absent a valid, substantive insurance claim.” Since plaintiff’s underlying claim was prescribed, she had no cause of action for bad faith damages against the insurer.

- Clausen v. Fidelity & Deposit Co. of Maryland, 660 So.2d 83 (La.App. 1st Cir. 8/4/95)

The owner of three savings certificates issued by bank filed suit against bank’s insurer, alleging that, although funds were deposited at the bank, plaintiff never

received the funds. Plaintiff also brought a bad faith claim against the insurer under 22:658 and 22:1220 for breaching its duty to adjust claims fairly and promptly. Subsequently, plaintiff's underlying claim was dismissed via an exception of prescription. The court then dismissed plaintiff's bad faith claim stating, "penalties authorized by statute concerning insurer's unfair or deceptive practices and lack of good faith to fairly and promptly act upon claimant's loss of property do not provide a cause of action against the insurer absent a valid, underlying claim for which insurance coverage is due."

- Sutton v. Oncale, 765 So.2d 1072 (La. App. 5th Cir. 3/29/00)

Automobile accident victim brought action against tort-feasor, his liability insurer, and UM carrier. Victim settled the tort claim and sought penalties from the UM carrier for bad faith due to the carrier's failure to tender payments under the policy. The court stated that an insurer's refusal to pay is not arbitrary, capricious, or without probable cause where serious issues regarding the insured's right to recovery are raised. To prove insurer is in bad faith, plaintiff must first show he provided the insurer with "satisfactory proof of loss." To establish a "satisfactory proof of loss" and to recover for a UM carrier's alleged failure to timely pay, the insured needs to provide sufficient facts apprising the carrier that (1) the owner or operator of the other vehicle was uninsured or underinsured, (2) he was at fault, (3) such fault gave rise to damages, and (4) the damages exceeded the liability coverage.

- Reed v. State Farm Auto Ins. Co., 857 So.2d 1012 (La. 10/21/03)

Insured, who was injured in traffic accident brought suit against UM insurer, alleging insurer acted arbitrarily and capriciously in failing to timely tender payment under the policy. The court stated that for purposes of the bad faith statutes, the insured is required to supply a "satisfactory proof of loss." In the context of UM coverage, this requires the insured to supply the insurer with sufficient facts which fully apprise the insurer that: (1) the owner or operator of the other vehicle was uninsured or underinsured; (2) he was at fault; (3) such fault gave rise to damages; and (4) the damages exceeded the liability coverage. In this case, the insurer did not receive satisfactory proof of loss regarding insured's injuries to her right knee (which

were allegedly sustained in the auto accident). Thus, the insurer's tender of 30% of the policy limits was neither untimely nor inadequate.

D. *Plaintiff's errors or fault can be a defense.*

- Block v. St. Paul Fire & Marine Ins. Co., 742 So.2d 746 (La.App. 2nd Cir. 9/22/99)

Insured brought an action against his homeowners' insurer to recover payments for damage to the foundation of his home. Additionally, the plaintiff asserted a bad faith claim, alleging the insurer failed to timely initiate an investigation and payment of the claim. The facts presented at trial established that the plaintiff submitted the claim on April 7, 1997 to the wrong person, a former employee/agent of the insurer, who no longer worked for the company. As a result, the insurer did not receive notice of the claim until June 3, 1997. The court held that in light of the delay caused primarily by the plaintiff, the insurer was not in bad faith for failing to timely investigate and tender payment of the claim.

- Fleming v. American Auto. Association, 764 So.2d 274 (La.App. 4th Cir. 6/21/00)

A tourist brought an action against her travel insurer, the policy administrator, the medical assistance contractor, and the wholesale tour provider to recover damages for her injuries resulting from a faulty medical evacuation and also for bad faith damages for breaching the duty of good faith and fair dealing under Section 1220. The plaintiff asserted that the defendant insurer should be subject to penalties due to their delay in paying the claim. According to the facts, the defendants made numerous requests for the plaintiff to submit completed claim forms and certain medical records so that they could properly evaluate the plaintiff's claim. The plaintiff failed to respond to the requests even after she was informed that her claim file would be closed if the requested documents were not provided within sixty days. Due to the plaintiff's delay in submitting the requested documents, the court held that the plaintiff's bad faith claims were without merit.

- McClendon v. Economy Fire & Casualty Ins. Co., 732 So.2d 727 (La.App. 3rd Cir. 4/7/99)

The plaintiff, McClendon, was injured in an auto accident caused by Ms. Jones. The plaintiff settled with Ms. Jones' liability insurer, Safeway, on April 15, 1997. Subsequently, on April 21, 1997, the plaintiff filed suit against the UM carrier, Economy, seeking UM benefits, penalties, and attorney's fees. Economy was not told that the limits of the Safeway policy were exhausted or of the amount the plaintiff received in settlement. It was not until June 11, 1997 that Economy was informed that the limits of the Safeway were exhausted. Economy made an unconditional tender of benefits on July 11, 1997. The court refused to award the plaintiff penalties and attorney's fees, stating that the untimely tender of benefits was due to the plaintiff's failure to provide information to Economy.

- Reed v. State Farm Auto Ins. Co., 857 So.2d 1012 (La. 10/21/03)

Insured, who was injured in a traffic accident, brought action against UM insurer, alleging insurer acted arbitrarily and capriciously in failing to timely tender payment under the policy. In the context of UM coverage, one of the requirements for the insured to establish a satisfactory proof of loss is that the insured must submit proof that the other driver was underinsured. In this case, the court held that plaintiff's failure to provide the insurer with information to confirm that the other driver was underinsured barred a finding of arbitrary or capricious failure to tender within 60 days.

E. *La. R.S. 22:656-658 and La. R.S. 22:1220 must be strictly construed.*

- Houston v. Blue Cross Blue Shield of LA, 843 So.2d 542 (La.App. 2nd Cir. 4/9/03)

Insured sued her insurer for failing to timely pay benefits for medical treatment under a cancer policy. From February, 1999 to October 2000, the insured received

treatment for a brain tumor. During that time, the insured had in effect a Cancer and Serious Disease Policy issued by Blue Cross Blue Shield of LA, the insurer. On May 11, 2000, Mr. Parker, the insured's son who had power of attorney, mailed certain documents to the insurer that would be necessary for them to process his mother's claim. The insurer refused to process the claim and sent out form letters requesting additional information from the providers, which went unanswered. However, at no time did the insurer attempt to contact the insured or her son. The claim evaluation remained stagnant until a demand letter was sent by Mr. Parker on July 27, 2000. Suit was filed on August 15, 2000, alleging bad faith under La. R.S. 22:657. The court stated that the provisions of La. R.S. 22:657 are penal in nature and are to be strictly construed. "Such penalties should not be assessed unless the refusal to pay is clearly arbitrary and capricious." The court found that the information sent by the insured on May 11, 2000 was sufficient to allow the insurer to process the claim and therefore found the insurer's delay in tendering payment was unjustified and unreasonable, subjecting the insurer to penalties under an even strict interpretation of La. R.S. 22:657.

- Maurice v. Prudential Ins. Co., 831 So.2d 381 (La.App. 4th Cir. 10/23/02)

Insured brought action against insurer, seeking coverage under homeowner's policy for damages to his home resulting from hailstorm. Insured also filed suit for bad faith damages, penalties, and attorney's fees, alleging that the insurer had failed to promptly pay this claim. There was a factual dispute as to whether the roof damage was actually caused by the hailstorm. The court stated that because the statutes are penal in nature, they must be strictly construed and penalties should not be assessed unless it is clearly shown that the insurer was in fact arbitrary, capricious, and without probable cause in refusing to pay. Under a strict interpretation of the statutes, the plaintiff must meet his burden of proving the insurer had no reasonable basis in denying the claim. In this case, the plaintiff did not come forth with evidence to controvert the insurer's assertion that the damage was not caused by the hailstorm. Accordingly, the court held that bad faith could not be inferred where the insurer had a legitimate question as to the extent and causation of the claim.

- Rawls v. City of Bastrop, 873 So.2d 934 (La.App. 2nd Cir. 5/12/04)

Several vehicle owners brought a property damage action against the City of Bastrop, which was self-insured, alleging their vehicles were damaged by paint “overspray” from negligent painting of a municipal building. Additionally, the plaintiffs sought bad faith penalties under La. R.S. 22:1220. The court stated that the statutes requiring timely payment of insurance claims, and imposing a duty of good faith and fair dealing on the insurer, are penal in nature and therefore, must be strictly construed. Interpreting La. R.S. 22:1220 strictly, the court found that the City, which was self-insured, was not an “insurer” by definition under the statute. “The legislature intended to include only those entities engaged in the business of insurance.” “Because the penal provisions of this statute must be strictly construed, they cannot be applied by analogy to the City when the City does not fall within the plain reading of the words of the statute and therefore, the City was not subject to the good faith and fair dealing provisions of the Insurance Code.”

- Bennet v. State Farm Ins. Co., 869 So.2d 321 (La.App. 3rd Cir. 3/24/04)

Insured filed suit against his homeowner’s insurance carrier, alleging that the carrier failed to adhere to its responsibilities under its policy by not paying him for the damage to his home in the wake of storm damage. The insured also asserted bad faith claims, alleging that the insurer cancelled his policy as a result of his numerous homeowners claims, that it failed to fairly adjust his claims, and that it misled him regarding the applicable prescriptive period with regard to his claims. The court stated that under a strict interpretation of La R.S. 22:658 and La. R.S. 22:1220, penalties may not be imposed on an insurer for cancelling a policy. Additionally, the court found that the insurer’s adjuster did not mislead the plaintiff as to the applicable prescriptive period. With regard to the plaintiff’s claim that the insurer failed to fairly adjust the claim, the court dismissed the argument finding that there was a legitimate factual dispute as to which of three different storms actually caused the damage. “Because La. R.S. 22:1220 is penal in nature and must be strictly construed, the insurer should have the right to litigate claims without being subjected to damages and penalties.”

- Robin v. Allstate Ins. Co., 870 So.2d 402 (La.App. 3rd Cir. 3/24/04)

Insureds, husband and wife, filed suit against their auto liability insurer for damages resulting from the insurer's alleged breach of contract, and for bad faith damages resulting from the insurer's failure to settle the underlying tort action. According to the court, the insurer made an offer to settle within the two week period following the accident but the insured refused. Two years later, the insureds provided the insurer with a settlement package; but by that time, a dispute over the extent of the medicals bills had arisen. Additionally, a lapse in the treatment raised a significant question of causation. The insurer and insureds could not come to an agreement on the proper amount of settlement, and suit was filed. The court stated: "We cannot say that choosing to litigate this claim under the specific circumstances of this case was an act of bad faith." The court held that under a strict interpretation of the statute, where the insurer has presented a reasonable defense for its failure to timely tender payment, based on documentation of the victim's medical condition and future expenses, the penalty provisions of the statute governing the insurer's duty of good faith should not apply.

- Ibrahim v. Hawkins, 845 So.2d 471 (La.App. 1st Cir. 2/14/03)

Insured was injured in an auto accident and brought an action against the other motorist, the motorist's liability insurer, and the insured's UM carrier. The insured asserted a bad faith claim against his UM carrier, alleging that it arbitrarily refused to tender a reasonable amount under the policy. The court agreed with the plaintiff that the insurer was unreasonable and in bad faith for not timely tendering payment under the policy. However, the court held that under a strict interpretation of the policy, the insured must prove he suffered actual damages as a result of the insurer's bad faith failure to tender, not just that the insurer was in bad faith. "La. R.S. 22:1220 is a penal statute that must be strictly construed." Because the plaintiff failed to show he suffered any damages as a result of the insurer's bad faith, the court denied him any recovery on those grounds.

- Desoto v. Balbeisi, 837 So.2d 48 (La.App. 1st Cir. 12/20/02)

Insured driver filed a claim against her auto insurer for penalties and attorney fees due to the insurer's alleged failure to timely tender UM policy limits and medical benefits. The court concluded that the insurer was in bad faith for failing to make a reasonable tender under the policy. However, the court found that the attorney's fees awarded on the bad faith claim were excessive. The trial court awarded \$28,890 in attorney's fees based on the total recovery awarded rather than the attorney's efforts expended for "the prosecution and collection of [the insured's loss]" as required by La. R.S. 22:658. The First Circuit in disagreement with the Fourth Circuit (see Daney v. Haynes, 630 So.2d 955), did not interpret the word "loss" as used in La. R.S. 22:658 to include penalties and attorney fees. Rather, the court stated that the word "loss" simply refers to the "amount of any claim due any insured." The First Circuit reduced the trial court's award of attorney fees to \$2,500, stating that while the statutory penalty is penal in nature, the "reasonable attorney's fees" recoverable under the statute are intended as reimbursement for the insured's legal expenses incurred in recovering the loss, not as a windfall and since the statute is penal in nature, it must be strictly construed.

- Vaughn v. Franklin, 785 So.2d 79 (La.App. 1st Cir. 3/28/01)

Plaintiff filed suit for personal injury arising out of a crop-duster's aerial spraying. The suit was filed against the pilot/crop-duster, the farmer, and each of their liability insurers. The farmer's liability insurer filed a cross-claim against the crop-duster's insurer to recover contribution, defense costs, and penalties under La. R.S. 22:1220. The basis for the insurer's cross-claim relevant to the bad faith penalties claim was that it was conventionally subrogated to the insured's rights against the crop-duster's insurer, including the rights to any bad faith damages. After reviewing the jurisprudence, the court found no authority to allow an insurer to recover penalties and attorney's fees under La. R.S. 22:658 as an insured's subrogee for breach of the duty to defend. The court stated that a strict construction of the statute does not allow for recovery of penalties and attorney's fees by an insurer who is subrogated to the rights of an insured. Rather, the statute was intended to protect insureds who were harmed by the arbitrary, capricious, or bad faith actions of their insurers.

- Schmidt v. Blue Cross & Blue Shield of La., 769 So.2d 179 (La. App. 2nd Cir. 9/27/00)

In September, 1998, plaintiff was taken to the hospital's emergency room. Upon her arrival, she reported that she had taken 20 Xanax pills and 20 Trazodone pills. She told the hospital staff that "she could not take it anymore with four children and a decreasing income." The emergency room physician's impression was an intentional drug overdose. Blue Cross denied payment of Schmidt's medical bills because its policy excluded coverage for "intentional self-inflicted injury or sickness." After receiving the denial of benefits, Schmidt's psychiatrist wrote a letter, stating that she did not intentionally try to kill herself. Rather, her actions were the result of her mental illness. Blue Cross maintained its denial of coverage, and the case went to trial on the question of penalties and attorney's fees pursuant to La.R.S. 22:657. The Second Circuit reversed the trial court's award of penalties. According to the Court, La. R.S. 22:657 must be strictly construed. Blue Cross was entitled to weigh the direct evidence of Schmidt's denial of attempted suicide and the psychiatrist's opinion supporting her claim against the other facts which inferred an intentional injury, without being subject to penalties.

F. *The insurer takes the risk of misinterpreting its own policy.*

- Dawson Farms, L.L.C. v. Millers Mutual Fire Ins. Co., 794 So.2d 949 (La.App. 2nd Cir. 8/1/01)

Dawson Farms, a grower and seller of sweet potatoes, had a facility/warehouse built to store its crop. Due to a faulty design and workmanship, the facility allowed an accumulation of condensation, which resulted in the destruction of a portion of Dawson's sweet potato crop. Dawson filed a claim with its property insurer to recover the damages to the crop. The insurer denied the claim; and, Dawson filed suit against the insurer, claiming damages for the cost to repair the facility, damages due to the lost crop, penalties and attorney's fees. A jury concluded that Dawson failed to prove coverage under the policy. On appeal, the Second Circuit held that the policy excluded coverage for the cost to repair the facility caused by the faulty design and poor workmanship. However, the policy did not clearly and unambiguously

exclude coverage for the losses associated with the damage to the sweet potatoes. Dawson was entitled to \$105,000 for the damaged contents of the building. The court also held the insurer liable for penalties and attorney's fees, stating that "the insurer must take the risk of misinterpreting its policy provisions; if it errs in interpreting its own insurance contract, such error will not be considered as reasonable grounds for delaying payment of benefits." The court assessed a 10% penalty as well as \$30,000 in attorney's fees pursuant to La.R.S. 22:658.

- Holland v. Golden Rule Ins. Co., 688 So.2d 1186 (La.App. 3rd Cir. 10/9/96)

Insured's son was involved in an accident and sustained injuries to his teeth. He underwent outpatient dental services. The insured submitted these expenses to the insurer, who refused to pay them. In the insurance policy, Exclusion "J" excluded coverage for dental expenses unless those expenses were the result of an injury to the covered person's natural teeth. Exclusion "O" excluded all expenses incurred for outpatient services "unless expressly provided for by this policy." The insured argued that the exception in Exclusion "J" was coverage expressly provided by the policy, thereby overriding Exclusion "O." The insurer argued that Exclusion "O" prevailed. The trial court ruled in favor of the insured and also awarded penalties and attorney's fees pursuant to La. R.S. 22:657. On appeal, the Third Circuit affirmed the decision, stating that both the insured's and insurer's interpretations of the policy were reasonable. However, any ambiguity must be resolved in favor of the insured. "With regard to penalties and attorney's fees, the insurer runs the risk of misinterpreting its own policy and such error will not be considered reasonable grounds for delaying the payment of benefits."

- Vaughn v. Franklin, 785 So.2d 79 (La.App. 1st Cir. 3/28/01)

Bad faith means more than mere bad judgment or negligence by an insurer; it implies a dishonest purpose or evil intent. Arbitrariness is a more venial offense; it is a willful and unreasonable action, without consideration for the facts and circumstances presented, or acting with unfounded motivation. While a court may disagree with the interpretation the insurer places on its policy, its actions in refusing to pay should not necessarily subject it to penalties and attorney's fees.

G. *Misrepresentation in the insurance application due to an agent's negligence may be attributed to the agent, relieving the insurer from bad faith liability for not tendering benefits owed to the insured.*

- Toups v. Equitable Life Assurance, 657 So.2d 142 (La.App. 3rd Cir. 5/3/95)

Insured filed a claim with her insurer to recover benefits under a disability income insurance policy. The insurer honored the claim for benefits for two months but later suspended the benefits on the basis of a material misrepresentation in the application. The insured filed suit to recover the benefits and penalties pursuant to La. R.S. 22:657. Eventually, it was discovered that the misrepresentations were due to the negligence of the insurer's agent in completing the application. Thereafter, the insurer filed a third party demand for indemnity against the agent. Initially, the Third Circuit ruled for the plaintiff, awarding damages against the insurer and denying the insurer's claim for indemnity. However, on rehearing, the court reversed, stating that "where an insurer is exposed to liability for policy claims because of the actions of an agent beyond the agent's authority or contrary to his instructions, the agent is accountable to the insurer for the latter's loss." The court did not find the insurer's actions to be arbitrary and capricious.

H. *Within the statutory thirty day period, the insurer must show that some investigation occurred.*

- Houston v. Blue Cross Blue Shield of La., 843 So.2d 542 (La.App. 2nd Cir. 4/9/03)

Insured sued her insurer for failure to timely pay benefits for medical treatment under a cancer policy. From February, 1999 to October 2000, the insurer received treatment for a brain tumor. During that time, the insured had in effect a Cancer and Serious Disease Policy issued by Blue Cross/Blue Shield of La. On May 11, 2000, Mr. Parker, the insured's son who had power of attorney, mailed certain documents to the insurer that would be necessary for them to process his mother's claim. The insurer refused to process the claim and sent out form letters requesting additional

information from the providers, which went unanswered. However, at no time did the insurer attempt to contact the insured or her son. The claim evaluation remained stagnant until a demand letter was sent by Mr. Parker on July 27, 2000. Suit was filed on August 15, 2000, alleging bad faith under La. R.S. 22:657. The court held that the nearly four-month delay in paying benefits was due to the insurer's failure to take reasonable action to resolve the claim. The insurer failed to check its records which would have allowed it to process the claim more quickly. Thus, the insurer's failure to pay benefits within the thirty-day period was arbitrary and capricious. "Once an insurer has notice that a claim exists, it has a duty to investigate that claim, and the burden shifts to the insurer to show just and reasonable grounds for the delay under La. R.S. 22:657 which requires payment within thirty days of proof of the claim."

- Clark v. McNabb, 878 So.2d 677 (La.App. 3rd Cir. 5/19/04)

Insured brought an action against his auto insurer to recover for bad faith failure to pay the value of his totaled vehicle. The insurer made an inadequate tender based on an erroneous value it placed on the vehicle. The court held that the automobile insurer arbitrarily and capriciously failed to complete their investigation within the statutory period. If the insurer had further investigated the claim by immediately obtaining an estimate from the salvage dealer, it would have had the correct amounts in order to negotiate a good faith settlement. The insurer's failure to complete its investigation resulted in \$2,500 in penalties and attorney's fees.

- Deutschmann v. Rosiere, 844 So.2d 1082 (La.App. 4th Cir. 4/9/03)

Insured filed an action against her insurer after the insurer terminated her health insurance policy, seeking damages for wrongful cancellation, penalties, and attorney's fees. The basis for the insurer's cancellation was alleged misrepresentations in the insured's application. At trial, evidence was presented showing that the insurer never really inquired into the truthfulness of the insured's assertions in her application. In fact, the insurer did not contact all of the insured's doctors to verify whether the insured misrepresented facts in the application. Had the insurer conducted a reasonable investigation, it would have known that it had little ground for terminating the policy. Granting the plaintiff's claim for penalties and

fees, the court stated that “an insurer has an affirmative duty to verify, through a reasonable investigation, whether a claim was actually excluded from coverage.” “When an insurer chooses to resist its contractual obligation based upon a supposed defense, which a reasonable investigation would have proved to be without merit, it acts at its peril and renders itself liable for statutory penalties and attorney’s fees.”

- Gibson v. Allstate Ins. Co., 832 So.2d 1209 (La.App. 3rd Cir. 12/11/02)

Insured filed a claim with his homeowner’s insurer to recover losses from an alleged burglary. The insurer denied the insured’s claim, alleging he had not provided adequate proof of ownership. None of the insurer’s agents or investigators ever visited the home or met with the insured in person. The extent of the insurer’s investigation was a telephone conversation with the Rayne Police Dept. The court found that the insured provided sufficient proof of ownership as to the stolen items and the insurer made no real effort to determine if the items claimed to be stolen existed until after the claim was denied. The court stated, “if an insurer has questions regarding the validity of a claim, the insurer must nevertheless investigate that claim within the statutory period.” The Third Circuit awarded the plaintiff over \$7,000 in penalties and attorney’s fees.

- I. ***Plaintiff cannot recover penalties under both 22:658 and 22:1220, but plaintiff could get attorney’s fees under 22:658 and penalties under 22:1220.***

- Calogero v. Safeway Ins. Co. of La., 753 So.2d 170 (La. 1/19/00)

Insureds brought an action against their automobile insurer to recover for property loss and alleged bad faith denial of their claim. The insurer’s denial was based on a “named driver” exclusion in the policy. The Louisiana Supreme Court disagreed with the insurer’s denial of coverage under the policy and concluded that the insurer was arbitrary and capricious in denying coverage. The main issue was whether the plaintiffs were allowed to collect bad faith penalties under both 22:658

and 22:1220. The court held that the insured could not recover penalties under both statutes but they could get penalties under 22:1220 and attorney's fees under 22:658.

- Ibrahim v. Hawkins, 845 So.2d 471 (La.App. 1st Cir. 2/14/03)

Insured was injured in an auto accident and brought an action against the other motorist, the motorist's liability insurer, and the insured's UM carrier. The insured asserted a bad faith claim against his UM carrier, alleging that it arbitrarily refused to tender a reasonable amount under the policy. The court agreed with the plaintiff that the insurer was unreasonable and in bad faith for not timely tendering payment under the policy. The plaintiff sought to recover penalties under both 22:658 and 22:1220. The court held that, where 22:1220 provides the greater penalty, it supersedes 22:658, such that the insured cannot recover penalties under both statutes. However, because 22:1220 does not provide for attorney's fees, the insured is entitled to recover the greater penalties under its provisions, as well as attorney's fees under 22:658.

- Clark v. McNabb, 878 So.2d 677 (La.App. 3rd Cir. 5/19/04)

Insured brought an action against his auto insurer to recover for bad faith failure to pay the value of his totaled vehicle. The insurer made an inadequate tender based on an erroneous value it placed on the vehicle. The court held that the automobile insurer arbitrarily and capriciously failed to complete its investigation within the statutory period. The plaintiff asked the court to award penalties and attorney's fees under both 22:658 and 22:1220. The court held that where 22:1220 provides the greater penalty, it supersedes 22:658, such that the insured cannot recover penalties under both statutes. However, because 22:1220 does not provide for attorney's fees, the insured is entitled to recover the greater penalties under its provisions and attorney's fees under 22:658.

J. *Legal interest is owed from the date of judgement, not judicial demand.*

- Becnel v. Lafayette Ins. Co., 773 So.2d 247 (La.App. 4th Cir.

11/15/00)

Insured brought an action against his property insurer to recover the cost to replace a barn and the roof of his house damaged by hail and to recover penalties and attorney fees for bad faith under La. R.S. 22:658 and 22:1220. The trial court held for the plaintiff and awarded him bad faith damages plus interest from the date of judicial demand. On appeal, the Fourth Circuit stated that “until a judgment is rendered awarding attorney’s fees or penalties, a claim for those damages is unliquidated, that is, it is a claim that has not been determined either as to liability or damages.” Accordingly, the trial court’s judgment was amended to award interest on the penalties and fees from the date of the judgment, rather than the date of judicial demand.

- Dawson Farms, L.L.C. v. Millers Mutual Fire Ins. Co., 794 So.2d 949 (La.App. 2nd Cir. 8/1/01)

Dawson Farms, a grower and seller of sweet potatoes, had a facility/warehouse built to store its crop. Due to a faulty design and workmanship, the facility allowed an accumulation of condensation which resulted in destruction of a portion of Dawson’s sweet potato crop. Dawson filed a claim with its property insurer to recover the damages to the crop. The insurer denied the claim; and, Dawson filed suit against the insurer, claiming damages for the cost to repair the facility, damages due to the lost crop, penalties and attorney’s fees. A jury concluded that Dawson failed to prove coverage under the policy. On appeal, the Second Circuit held that the policy excluded coverage for the cost to repair the facility caused by the faulty design and poor workmanship. However, the policy did not clearly and unambiguously exclude coverage for the losses associated with the damage to the sweet potatoes. Dawson was entitled to \$105,000 for the damaged contents of the building. The court also held the insurer liable for penalties and attorney’s fees and assessed a 10% penalty as well as \$30,000 in attorney’s fees pursuant to La. R.S. 22:658, plus legal interest. The Second Circuit stated that legal interest on claims awarded under La. R.S. 22:658 is due from the date of the judgment, not the date of judicial demand.

II. SEVERING THE BAD FAITH CLAIM FROM THE UNDERLYING CLAIM

- Dugas v. Auto. Casualty Ins. Co., 729 So.2d 25 (La.App. 5th Cir. 2/10/99)

This case involves an automobile accident that occurred in Jefferson Parish between a vehicle owned and operated by Mr. Dugas, and one owned and operated by Mr. Medrzykowski, hereafter referred to as “Mr. M”. Mr. Dugas filed a petition for damages against Mr. M and Mr. M’s auto insurer, Auto Casualty Insurance Company. Mr. Dugas subsequently filed a supplemental and amending petition naming his insurer, USAA, claiming UM benefits. In his supplemental petition, the plaintiff alleged that USAA violated the provisions of La. R.S. 22:658 and 22:1220 by failing to pay his claim within thirty and sixty days, respectively, after receipt of satisfactory proof of loss. Pursuant to these violations, the plaintiff sought to recover penalties and attorney’s fees, in addition to compensatory damages. Prior to jury selection, USAA suggested that the issue of compensatory damages should be tried separately from the issues of bad faith, penalties, and attorney’s fees. The trial judge so ordered, despite an objection by plaintiff’s counsel.

In his reasons for separating the claims, the trial judge reasoned as follows: “I ordered in this case, pursuant to Article 1632 of the Code of Civil Procedure, that the order of what, in my mind, I deemed to be one trial, be altered because I believed that the circumstances justified altering the Order of Trial. I ordered the parties to give their opening statements only on the compensatory case, and thereafter, in the normal order of trial, present their evidence to the jury, on the issues relevant to the compensatory claim only. I then ordered the jury to leave and deliberate on the compensatory issue, and immediately upon the conclusions of the jury’s deliberations, the parties would address by opening statement the punitive and bad faith claims.” On appeal, the plaintiff claimed that the trial court erred in ordering that the issue of compensatory damages be tried separately from the issues of bad faith, penalties, and attorney’s fees, absent the consent of all parties. The Fifth Circuit upheld the trial court’s decision to sever the bad faith claim, stating that by separating the issues, the judge clearly helped to prevent jury confusion insofar as some items of evidence would have been admissible in the penalties phase of the trial but not in the compensatory damages phase. However, the court did subsequently reverse the trial

court's decision to grant the defendant a directed verdict on the claims for penalties and attorney's fees because the trial court did not allow submission of testimony and evidence on those issues.

- Mitchell v. State Farm Fire & Casualty Company, 473 So.2d 399 (La.App. 3rd Cir. 1985)

Plaintiff sued the fire insurer and the E&O carrier of his insurance agent. The fire insurer raised the affirmative defense of misrepresentation by the plaintiff on his application. Plaintiff filed a motion in limine and a motion to sever. Under La. R.S. 22:618(A), the application was critical in the plaintiff's action against the E&O carrier. Under those circumstances, the Third Circuit granted the motion to sever the claims. The court stated that it would be unreasonable to expect a jury to understand the complications of both of the claims when the application is admissible in one and inadmissible in the other. Arguably, the *Mitchell* case can be applied by analogy when an insurer is seeking severance of a 22:658 or 22:1220 claim from an underlying claim for insurance coverage.

III. SEVERING DISCOVERY OF THE BAD FAITH FROM THE UNDERLYING CLAIM

- Conseco, Inc. v. National Union Fire Ins. Co. of Pitt., PA., 2002 WL 31961447 (Ind. App. 2002)

Plaintiffs, Conseco Inc. and its directors and/or officers, filed suit against their insurer, Royal Insurance Company of America, for liability coverage in Conseco, Inc.'s defense of a securities fraud class action. Conseco also asserted a claim under Indiana law against Royal, alleging that it was in bad faith for not timely tendering a settlement under the policy. On appeal, Royal argued, among several other issues, that the trial court erred in bifurcating the bad faith and coverage portions of the trial. The appellate court, upholding the trial court's decision, stated that "there can be no action for bad faith without adjudication that there is coverage under the insurance policy. Moreover, courts bifurcate insurance disputes such that the bad faith portion

of the case including discovery, does not proceed unless there is first a finding of coverage”, citing *In re Trinity Universal Ins. Co.*, 64 S.W.3d 463 (Tx.App. 2001); *Imperial Cas. and Indemnity Co. v. Bellini*, 746 A.2d 130 (R.I. 2000); and *Corrente v. Fitchburg Mutual Fire Ins. Co.*, 557 A.2d 859 (R.I.1989). The Indiana court stated that Indiana case law is consistent with the position that discovery on the bad faith claim should be enjoined pending a finding of coverage.

- Dahmen v. American Family Mutual Ins. Co., 635 N.W.2d 1 (Wis.App.198 8/1/01)

Insureds brought an action against their automobile insurer, alleging a claim for benefits under their UM policy and asserting a bad faith claim. The trial court denied the insurer’s motion to bifurcate the claims for trial and to stay discovery on the bad faith claim pending resolution of the coverage claim. The appeals court reversed the trial court’s decision, bifurcated the trial, and stayed discovery on the bad faith claim. The court stated that in an insured’s action for benefits under a UM policy and bad faith damages, the insurer is entitled to bifurcation of the claims and to stay discovery on the bad faith claim pending resolution of the UM claim. The court reasoned that litigating the bad faith claim would entitle the insureds to discovery of the insurer’s work-product and privileged attorney/client material regarding how the claim was handled, including an evaluation as to how a jury might value the claim and approach to settlement. The court stated that this would significantly prejudice the insurer in defending the contract claim and could interfere with settlement negotiations, as well as confuse the jury in distinguishing between the two claims.

- Allstate Ins. Co. v. Swanson, 506 So.2d 497 (Fla.App. 5th Dist. 5/7/87)

Insurer sought certiorari review of an order compelling discovery of its entire “claim file” in an action alleging both the existence of coverage and bad faith refusal to settle within the policy limits. The Florida Fifth District Court of Appeal held that in a bad faith suit against an insurer for failure to settle within the policy limits, plaintiff may obtain discovery of insurer’s complete claim file, but if the suit is simply to establish a right to recovery, the plaintiff cannot compel disclosure of privileged

matters. “In a suit seeking to establish both the existence of coverage and bad faith, the plaintiff may not obtain discovery of the insurer’s original claim file, including privileged matters, until the issue of coverage has been resolved.”

- State Farm Fire & Casualty Co. v. Madden, 451 S.E.2d 721 (W. Va. 10/28/94)

A pedestrian, who was injured in a slip and fall accident outside of a restaurant, brought an action against the restaurant to recover for his injuries and against the liability insurer and adjuster for bad faith and unfair insurance practices. The West Virginia court held that bifurcation of the claims was warranted so that the personal injury action against the insured would be tried before the plaintiff’s claims for bad faith; allowing the bad faith claims against the insurer to proceed would entail discovery of its files and would prejudice the insurer’s ability to defend itself in the personal injury action.

- Garg v. State Auto. Mutual Ins. Co., 800 N.E.2d 757 (Ohio App. 2nd Dist. 11/7/03)

Insured moved to compel discovery of withheld “claims file” documents in an action against insurer, which had issued a commercial fire policy and a commercial general liability policy. The insured asserted claims for breach of contract, bad faith, and unfair claims practices. The Ohio court stated that the bad faith claim was required to be bifurcated from the other claims and discovery stayed until resolution of the other claims. Although the insured was entitled to discovery of certain “claims file” documents of the insurer, which documents contained attorney/client and work product information, for purposes of the insured’s bad faith claim, such materials were not discoverable for purposes of the insured’s breach of contract claim. Therefore, the bad faith claim had to be bifurcated from the other claims; and, discovery on the bad faith claim had to be stayed. “To require insurer to divulge its otherwise privileged information prior to a resolution of the breach of contract and unfair claims practices claims would have unquestionably impacted the insurer’s ability to defend against them.”

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APPENDIX “A”

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APPENDIX “B”

LSA R.S. 22:657 **Payment of claims; health and accident policies; prospective review; penalties; self-insurers; telemedicine reimbursement by insurers**

A. All claims arising under the terms of health and accident contracts issued in this state, except as provided in Subsection B, shall be paid not more than thirty days from the date upon which written notice and proof of claim, in the form required by the terms of the policy, are furnished to the insurer unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. The insurer shall make payment at least every thirty days to the assured during that part of the period of his disability covered by the policy or contract of insurance during which the insured is entitled to such payments. Failure to comply with the provisions of this Section shall subject the insurer to a penalty payable to the insured of double the amount of the health and accident benefits due under the terms of the policy or contract during the period of delay, together with attorney's fees to be determined by the court. Any court of competent jurisdiction in the parish where the insured lives or has his domicile, excepting a justice of the peace court, shall have jurisdiction to try such cases.

B. All claims for accidental death arising under the terms of health and accident contracts where such contracts insure against accidental death shall be settled by the insurer within sixty days of receipt of due proof of death and should the insurer fail to do so without just cause, then the amount due shall bear interest at the rate of six percent per annum from date of receipt of due proof of death by the insurer until paid.

C. Any person, partnership, corporation or other organization, or the State of Louisiana which provides or contracts to provide health and accident benefit coverage as a self-insurer for his or its employees, stockholders or any other persons, shall be subject to the provisions of this Section, including the provisions relating to penalties and attorney fees, without regard to whether the person or organization is a commercial insurer provided, however, this Section shall not apply to collectively bargained union welfare plans other than health and accident plans.

D. (1) In any event where the contract between an insurer or self-insurer and the insured is issued or delivered in this state and contains a provision whereby in non-emergency cases the insured is required to be prospectively evaluated through a pre-hospital admission certification, pre-inpatient service eligibility program, or any similar pre-utilization review or screening procedure prior to the delivery of contemplated hospitalization, inpatient or outpatient health care, or medical services which are prescribed or ordered by a duly licensed health care provider who possesses admitting and clinical staff privileges at an acute care health care facility or ambulatory surgical care facility, the insurer, self-insurer, third party administrator, or independent contractor shall be held liable in damages to the insured only for damages incurred or resulting from unreasonable delay, reduction, or denial of the proposed medically necessary services or care according to the information received from the health care provider at the time of the request for a prospective evaluation or review by the duly licensed health care provider, as provided in the contract; which damages shall be limited solely to the physical injuries which are the direct and proximate cause of the unreasonable delay, reduction, or denial as further defined in this Subsection together with reasonable attorney fees and court costs.

(2)(a) Any insurer, health maintenance organization, preferred provider organization, or other managed care organization requirement that the insured be prospectively evaluated through a pre-hospital admission certification, pre-inpatient service eligibility program, or any similar pre-utilization review or screening procedure shall be inapplicable to an emergency medical condition.

(b) Every insurer, health maintenance organization, preferred provider organization, or other managed care organization which includes emergency medical services as part of its policy or contract, shall provide coverage and shall subsequently pay providers for emergency medical services provided to an insured, enrollee, or patient who presents himself with an emergency medical condition. This Subparagraph shall not be construed to require coverage for illnesses, conditions, diseases, equipment, supplies, or procedures or treatments which are not otherwise covered under the terms of the insured's policy or contract. The provisions of this Subparagraph shall not apply to hospital indemnity, disability, or renewable limited benefit supplemental health insurance policies authorized to be issued in this state.

(c) An insurer, health maintenance organization, preferred provider organization, or other managed care organization shall not retrospectively deny or reduce payments to providers for emergency medical services of an insured, enrollee, or patient even if it is determined that the emergency medical condition, initially presented is later identified through screening not to be an actual emergency, except in the following cases:

(i) Material misrepresentation, fraud, omission, or clerical error.

(ii) Any payment reductions due to applicable co-payments, co-insurance, or deductibles which may be the responsibility of the insured.

(iii) Cases in which the insured does not meet the emergency medical condition definition, unless the insured has been referred to the emergency department by the insured's primary care physician or other agent acting on behalf of the insurer.

(d) Every insurer, health maintenance organization, preferred provider organization, or other managed care organization shall inform its insureds, enrollees, patients, and affiliated providers about all applicable policies related to emergency care access, coverage, payment, and grievance procedures. It is the ultimate responsibility of the insurer, health maintenance organization, or preferred provider organization to inform any contracted third party administrator, independent contractor, or primary care provider about the emergency care provisions contained in this Paragraph.

(e) Failure to comply with the provisions of Subparagraphs (a), (b), and (c) shall subject the insurer, health maintenance organization, preferred provider organization, or other managed care organization to penalties as provided for in Subsection A of this Section and to penalties for violations as provided in [R.S. 22:1217](#).

(f) The provisions of this Paragraph shall not apply to medical benefit plans that are established under and regulated by the Employment Retirement Income Security Act of 1974.

(g) As used in this Paragraph, the following definitions shall apply:

(i) "Emergency medical condition" is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in:

(aa) Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

(bb) Serious impairment to bodily function.

(cc) Serious dysfunction of any bodily organ or part.

(ii) "Emergency medical services" are those medical services necessary to screen, evaluate, and stabilize an emergency medical condition.

(iii) "Managed care organization" means a licensed insurance company, hospital or medical benefit plan or program, health maintenance organization, integrated health care delivery system, an employer or employee organization, or a managed care contractor which operates a managed care plan. A managed care organization may include but is not limited to a preferred provider organization, health maintenance organization, exclusive provider organization, independent practice association, clinic without walls, management services organization, managed care services organization, physician hospital organization, and hospital physician organization.

(iv) "Managed care plan" means a plan operated by a managed care entity which provides for the financing and delivery of health care and treatment services to individuals enrolled in such plan through its own employed health care providers or contracting with selected specific providers that conform to explicit selection, standards, or both. A managed care plan also customarily has a formal organizational structure for continual quality assurance, a certified utilization review program, dispute resolution, and financial incentives for individual enrollees to use the plan's participating providers and procedures.

(3)(a) For the purposes of this Subsection, a period of two working days from the time of the duly licensed health care provider's request to the insurer, self-insurer, third party administrator, or independent contractor for a pre-hospital admission or pre-inpatient service eligibility certification or any similar pre-utilization review or screening procedure confirmation until the receipt by the duly licensed health care provider of such insurer's, self-insurer's, third party administrator's, or independent contractor's certification, approval, or denial of the contemplated hospitalization, inpatient or outpatient health care, or medical services, shall not be considered unreasonable.

(b) For the purposes of this Subsection, a period in excess of two working days from the time of the duly licensed health care provider's request to the insurer, self-insurer, third party administrator, or independent contractor for a pre-hospital admission or pre-inpatient service eligibility certification or any similar pre-utilization review or screening procedure confirmation until the receipt by the duly licensed health care provider of such insurer's, self-insurer's, third party administrator's, or independent contractor's certification, approval, or denial of the contemplated hospitalization, inpatient or outpatient health care, or medical services may be considered unreasonable depending on the circumstances of each individual case.

(c) For the purposes of this Subsection, the term "unreasonable reduction" shall mean the decreasing or limiting of:

(i) Previously certified or approved health care or medical services as contracted for between the insurer and insured; or

(ii) Continued hospitalization and medical services without providing a procedure or method for certifying an extension of hospitalization and medical services by the insurer's or self-insurer's review or screening procedure in the event of continued hospitalization or medical attention, or both, as deemed medically necessary according to current established medical criteria.

(d) For the purposes of this Subsection an "unreasonable denial" shall mean the failure to:

(i) Review a request from a duly licensed health care provider by the insurer's or self-insurer's review or screening procedure; or

(ii) Review a request from the insured within the time period as provided for in the contract between the insurer or self-insurer and the insured, which time period shall not exceed two work days as provided for in Subparagraph 3(a); or

(iii) Deliver the contracted for health care or medical services previously certified or approved by the insurer's or self-insurer's review or screening procedure for medically necessary treatment or care as mandated by and provided for in the contract between the insurer or self-insurer and the insured; or

(iv) Review a request from a duly licensed health care provider by the insurer's or self-insurer's review or screening procedure for an extension of the original certified or approved duration of health care or medical services; or

(v) Extend the original certified or approved duration of hospitalization, health care or medical services requested by a duly licensed health care provider by the insurer's or self-insurer's review or screening procedure when treatment or care is deemed medically necessary according to current established medical criteria.

(e) For the purposes of this Subsection "medically necessary treatment or care", shall mean contemplated hospitalization, inpatient or outpatient health care or medical services recommended for appropriate treatment or care in accordance with nationally accepted current medical criteria.

(4) Any court of competent jurisdiction in the parish where the insured lives or has his domicile, excepting a justice of the peace court, has jurisdiction of cases arising under the provisions of Paragraph (1) of this Subsection.

E. No action for the recovery of penalties or attorney fees provided in this Section shall be brought after the expiration of one year after the date proofs of loss are required to be filed.

F. (1) Notwithstanding any provision of any policy or contract of insurance or health benefits issued after June 16, 1995 whenever such policy provides for payment, benefit, or reimbursement for any health care service, including but not limited to diagnostic testing, treatment, referral, or consultation, and such health care service is performed via transmitted electronic imaging or telemedicine, such a payment, benefit, or reimbursement under such policy or contract shall not be denied to a licensed physician conducting or participating in the transmission at the originating health care facility or terminus who is physically present with the individual who is the subject of such electronic imaging transmission and is contemporaneously communicating and interacting with a licensed physician at the receiving terminus of the transmission. The payment, benefit, or reimbursement to such a licensed physician at the originating facility or terminus shall not be less than seventy-five percent of the reasonable and customary amount of payment, benefit, or reimbursement which that licensed physician receives for an intermediate office visit.

(2) Any health care service proposed to be performed or performed via transmitted electronic imaging or telemedicine under this Subsection shall be subject to the applicable utilization review criteria and requirements of the insurer. Terminology in a health and accident insurance policy or contract that either discriminates against or prohibits such a method of transmitted electronic imaging or telemedicine shall be void as against public policy of providing the highest quality health care to the citizens of the state.

(3) The provisions of this Subsection shall not apply to individually underwritten limited benefit and supplemental health insurance policies authorized to be issued in the state.

LSA R.S. 22:658 Payment and adjustment of claims, policies other than life and health and accident; personal vehicle damage claims; penalties; arson-related claims suspension

A. (1) All insurers issuing any type of contract, other than those specified in [R.S. 22:656](#), [R.S. 22:657](#), and Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, shall pay the amount of any claim due any insured within thirty days after

receipt of satisfactory proofs of loss from the insured or any party in interest.

(2) All insurers issuing any type of contract, other than those specified in [R.S. 22:656](#), [R.S. 22:657](#), and Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, shall pay the amount of any third party property damage claim and of any reasonable medical expenses claim due any bona fide third party claimant within thirty days after written agreement of settlement of the claim from any third party claimant.

(3) Except in the case of catastrophic loss, the insurer shall initiate loss adjustment of a property damage claim and of a claim for reasonable medical expenses within fourteen days after notification of loss by the claimant. In the case of catastrophic loss, the insurer shall initiate loss adjustment of a property damage claim within thirty days after notification of loss by the claimant. Failure to comply with the provisions of this Paragraph shall subject the insurer to the penalties provided in [R.S. 22:1220](#).

(4) All insurers shall make a written offer to settle any property damage claim, including a third-party claim, within thirty days after receipt of satisfactory proofs of loss of that claim.

B. (1) Failure to make such payment within thirty days after receipt of such satisfactory written proofs and demand therefor or failure to make a written offer to settle any property damage claim, including a third-party claim, within thirty days after receipt of satisfactory proofs of loss of that claim, as provided in Paragraphs (A)(1) and (4), respectively, or failure to make such payment within thirty days after written agreement or settlement as provided in Paragraph (A)(2), when such failure is found to be arbitrary, capricious, or without probable cause, shall subject the insurer to a penalty, in addition to the amount of the loss, of twenty-five percent damages on the amount found to be due from the insurer to the insured, or one thousand dollars, whichever is greater, payable to the insured, or to any of said employees, or in the event a partial payment or tender has been made, twenty-five percent of the difference between the amount paid or tendered and the amount found to be due.

(2) The period set herein for payment of losses resulting from fire and the penalty provisions for nonpayment within the period shall not apply where the loss from fire was arson related and the state fire marshal or other state or local investigative bodies have the loss under active arson investigation. The provisions relative to time of payment and penalties shall commence to run upon certification of the investigating authority that there is no evidence of arson or that there is insufficient evidence to warrant further proceedings.

(3) The provisions relative to suspension of payment due to arson shall not apply to a bona fide lender which holds a valid recorded mortgage on the property in question.

(4) Whenever a property damage claim is on a personal vehicle owned by the third party claimant and as a direct consequence of the inactions of the insurer and the third party claimant's loss the third party claimant is deprived of use of the personal vehicle for more than five working days, excluding Saturdays, Sundays, and holidays, the insurer responsible for payment of the claim shall pay, to the extent legally responsible, for reasonable expenses incurred by the third party claimant in obtaining alternative transportation for the entire period of time during which the third party claimant is without the use of his personal vehicle. Failure to make such payment within thirty days after receipt of adequate written proof and demand therefor, when such failure is found to be arbitrary, capricious, or without probable cause shall subject the insurer to, in addition to the amount of such reasonable expenses incurred, a reasonable penalty not to exceed ten percent of such reasonable expenses or one thousand dollars whichever is greater together with reasonable attorneys fees for the collection of such expenses.

C. (1) All claims brought by insureds, worker's compensation claimants, or third parties against an insurer shall be paid by check or draft of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or his attorney, or upon direction of such claimant to one specified; provided, however, that the check or draft shall be made jointly to the claimant and the employer when the employer has advanced the claims payment to the claimant. Such check or draft shall be paid jointly until the amount of the advanced claims payment has been recovered by the employer.

(2) No insurer shall intentionally or unreasonably delay, for more than three calendar days, exclusive of Saturdays, Sundays, and legal holidays, after presentation for collection, the processing of any properly executed and endorsed check or draft issued in settlement of an insurance claim.

(3) Any insurer violating this Subsection shall pay the insured or claimant a penalty of two hundred dollars or fifteen percent of the face amount of the check or draft, whichever is greater.

D. (1) When making a payment incident to a claim, no insurer shall require that as a condition to such payment, repairs be made to a motor vehicle, including window glass repairs or replacement, in a particular place or shop or by a particular entity. Any insurer violating the provisions of this Subsection shall be fined not more than five hundred dollars for each offense.

(2) A violation of this Subsection shall constitute an additional ground, under [R.S. 22:1142](#), for the commissioner to refuse to issue a license or to suspend or revoke a license issued to any agent, broker, or solicitor to sell insurance in this state.

LSA R.S. 22:1220 Good faith duty; claims settlement practices; cause of action; penalties

A. An insurer, including but not limited to a foreign line and surplus line insurer, owes to his insured a duty of good faith and fair dealing. The insurer has an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant, or both. Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach.

B. Any one of the following acts, if knowingly committed or performed by an insurer, constitutes a breach of the insurer's duties imposed in Subsection A:

(1) Misrepresenting pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to pay a settlement within thirty days after an agreement is reduced to writing.

(3) Denying coverage or attempting to settle a claim on the basis of an application which the insurer knows was altered without notice to, or knowledge or consent of, the insured.

(4) Misleading a claimant as to the applicable prescriptive period.

(5) Failing to pay the amount of any claim due any person insured by the contract within sixty days after receipt of satisfactory proof of loss from the claimant when such failure is arbitrary, capricious, or without probable cause.

C. In addition to any general or special damages to which a claimant is entitled for breach of the imposed duty, the claimant may be awarded penalties assessed against the insurer in an amount not to exceed two times the damages sustained or five thousand dollars, whichever is greater. Such penalties, if awarded, shall not be used by the insurer in computing either past or prospective loss experience for the purpose of setting rates or making rate filings.

D. The provisions of this Section shall not be applicable to claims made under health and accident insurance policies.

E. Repealed by Acts 1997, No. 949, § 2.

F. The Insurance Guaranty Association Fund, as provided in [R.S. 22:1375](#) et seq., shall not be liable for any special damages awarded under the provisions of this Section.