

# **INSURER PENALTIES FOR CLAIMS HANDLING ABUSE IN LOUISIANA**

An Internal Publication

of

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IN LOUISIANA**

*by*  
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**I. INTRODUCTION AND OVERVIEW**

Prior to 1990, Louisiana had a fairly limited and simple scheme for penalties arising out of insurance claims. LSA-R.S.22:656-658 provided for penalties for failure to timely pay claims on most types of policies. In 1990, both LSA-R.S.22:1220 and an amendment to LSA-R.S.22:1214 became effective and greatly expanded the scope of penalty provisions. Now, six years later, we are beginning to see the jurisprudential interpretation of these statutory changes. This paper will briefly review the history

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of insurance penalties and focus on the following statutes as they exist and are interpreted today:

- 1) **LSA-R.S.22:656**
- 2) **LSA-R.S.22:657**
- 3) **LSA-R.S.22:658**
- 4) **LSA-R.S.22:1220**
- 5) **LSA-R.S.22:1213-1214**

In analyzing these statutes, the following basic questions will be addressed:

- A. Who has the right to make a claim?
- B. Who has the exposure to the claim?
- C. What are the elements of the claim?
- D. What damages and/or penalties are recoverable?

In some instances, the answers are fairly clear. In other instances, the answers are conflicting.

## **II. HISTORY**

Acts 1948, No. 195 is the source for most of the Insurance Code. LSA-R.S.22:656-658 and LSA-R.S.22:1213-1214 were enacted as part of this legislation.

**LSA-R.S.22:656** covered life insurance policies. It provided for a penalty of 6% on the amount unpaid from the time of receipt of "due proof of death" until payment when the insurer, without just cause, failed to pay the claim within 60 days from receipt of "due proof of death".

**LSA-R.S.22:657** covered health and accident policies. It provided for a penalty of double the amount due when the insurer failed to pay the claim within 30 days of receipt of written notice and proof of claim unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. It also provided for attorney's fees. Accidental death claims arising under health and accident policies were added to the statute in 1960 and were treated similarly to life insurance claims.

**LSA-R.S.22:658** covered all other types of policies. In 1983, LSA-R.S.23:1201.2 excluded workers' compensation policies. Failure to make payment within 60 days from receipt of satisfactory proof of loss, resulted in a 12% penalty plus reasonable attorneys fees if the failure to pay was arbitrary, capricious or without probable cause.

These penalties were all based on unjustified failures to pay the claim timely after adequate notice to the insurer. The penalties for Sections 657 and 658 were owed to the insureds only. See e.g. Clausen v. Fidelity and Deposit Co. Of Maryland, 660 So.2d 83 (1st Cir. 1995); Nettleton v. Audubon Insurance Co., 637 So.2d 792 (1st Cir. 1972); Jefferson Oncology v. Louisiana Health Services and Indemnity Co., 545 So.2d 1125 (5th Cir. 1989); Payton v. Colar, 518 So.2d 1104 (4th Cir. 1987); and Guillory v. Gulf South Beverages, Inc., 506 So.2d 181 (5th Cir. 1987). Obviously, with a death claim under Section 656, the penalties were due to the beneficiary since the insured was dead. Planned Investments, Inc. v. Brumfield, 319 So.2d 859 (1st Cir. 1975). These provisions were fairly simple, fairly similar and were designed to "cover the field" for abusive failures to pay claims.

Today, the picture has been changed dramatically. Certain portions of the above described statutes have been amended to provide for third party claims and to deal with specific abuses. Section 1220 has been added to provide for a fairly broad affirmative duty of good faith dealing, throughout the claims process, toward both insureds and third party claimants in some instances. Section 1214 has been amended to make a number of actions in the claims adjustment process an unfair trade practice. Generally, the duties of the insurer and the possible causes of action by plaintiffs have been increased significantly.

### III. ANALYSIS

To better understand the current state of the law, it is helpful to first review the basic statutes (LSA-R.S.22:656-658) in their current formulation. Next, a study of LSA-R.S.12:1220 and its interpretive jurisprudence is necessary. Finally, LSA-R.S.22:1213-1214 and its relationship to the other statutes should be considered.

Again, in each instance the operative questions are:

- A. Who has the right to make a claim?
- B. Who has the exposure to the claim?
- C. What are the elements of the claim?
- D. What damages and/or penalties are recoverable?

It is hoped that the result will be a clearer picture of the current rights and duties of insurers, insureds, third party claimants, and others involved in the claims process.

#### A. LSA-R.S.22:656

##### **Payment of claims; life policies; penalty**

All death claims arising under policies of insurance issued or delivered within this state shall be settled by the insurer within sixty days after the date of receipt of due proof of death, and if the insurer fails to do so without just cause, the amount due shall bear interest at the rate of eight percent per annum from date of receipt of due proof of death by the insurer until paid.

This review begins with this statute as it has undergone the least change and remains the simplest.

##### **1. Who has the right to make the claim?**

In these cases, the beneficiary, a person other than the insured makes the claim. Logically, that person is the one prejudiced by the unjustified failure to pay and should be the one to make the claim and the courts have so held. See Planned Investments, Inc. v. Brumfield, *supra*.

## **2. Who has exposure to the claim?**

The statutory language clearly imposes the duty and the penalty on the “insurer”. An “insurer” is defined to include “every person engaged in the business of making contracts of insurance, other than a fraternal benefit society”. LSA-R.S. 22:5(2) Insurance is defined as a “contract whereby one undertakes to indemnify another or pay a specified amount on determinable consequences”. LSA-R.S.22:5(1)(a). In most instances involving life policies, it is fairly easy to identify the person engaged in the business of making contracts to indemnify another or pay a specified amount upon determinable consequences (i.e. the insurer). However, this is not always the case, given myriad new methods of marketing policies as well as the increasing development of “full service” third party administrators and involvement of other insurance consultants. It may well be that the entity adjusting the claim and failing to act is not the “insurer”. However, it is the insurer who will pay the penalty. As these statutes are penal in nature, they are to be strictly construed. Hart v. Allstate Insurance Co., 437 So.2d 823 (La. 1983); Toups v. Equitable Life Assurance Co., 657 So.2d 142 (3rd Cir. 1995); and Shrader v. Life General Security Insurance Co. 588 So.2d 1309 (2nd Cir. 1991).

## **3. What are the elements of the claim?**

In order to recover under the statute, the claimant has to prove the following:

- a) The claim is a death claim;
- b) The policy was issued or delivered within the state of Louisiana;
- c) The insurer received due proof of death; and,
- d) The insurer failed without just cause to settle the claim within 60 days of receipt of due proof of death.

These elements give rise to several interesting questions.

To begin with, the mere fact that a claim arises from a life insurance policy does not necessarily mean that it is governed by this statute. It must be a death claim. See e.g. Carmouche v. Riverside Life Insurance Co., 459 So.2d 1353 (3rd Cir. 1984). Also, it does not matter if the policy provided for other types of benefits. Brasher v. Life Insurance Company of Louisiana, 306 So.2d 321 (3rd Cir. 1975).

The only exception is a claim for accidental death under a “health and accident” policy. These are covered by LSA-R.S.22:657(B) and will be discussed therein.

“Due proof of death” has not been defined by the jurisprudence. Tutorship of Price v. Standard Life Insurance Company, 569 So.2d 261 (2nd Cir. 1990) is an interesting case involving the issue. It seems that a death certificate would be “due proof of death”; but, failing that proof, it is unclear as to what is sufficient. It might be

analogized to “satisfactory proof of loss” under LSA-R.S.22:658 which has been defined as sufficient information to fully apprise the insurer of the claim. Khaled v. Windham, 657 So.2d 672 (1st Cir.1995).

“Without just cause” has been defined. Where the insurer has a reasonable ground to believe a defense to payment is valid, failure to pay is not considered “without just cause”. Carr v. Port Ship Service, Inc., 406 So.2d 632 (2nd Cir. 1981) and the cases cited therein.

**4. What damages and/or penalties are recoverable?**

The statutes specifically provides for a penalty of interest of 8% per annum on the amount due from the date of receipt of due proof of death until the date of payment. This is not legal interest, but rather is penalty interest. Legal interest from the date due until paid is awarded in addition to penalty interest. Massachusetts Indemnity and Life Insurance Co. v. Humphreys, 644 So.2d 818 (1st Cir. 1994); Brasher v. Life Insurance Company of Louisiana, *supra*. Since the statute is a penal one and does not provide for attorneys fees, such fees are not recoverable. Planned Investments, Inc. v. Brumfield, *supra*; Willis v. Willis, 287 So.2d 642 (3rd Cir. 1973).

**B. LSA-R.S.22:657**

**Payment of claims; health and accident policies; prospective review; penalties; self-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 of 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) Any 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 certified and determined as such by the attending physician in his medical judgment to be a physical condition which places the insured in imminent danger of death or permanent disability.

(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.

This statute began as a health and accident penalty provision but has been amended to also deal with other specific problems which have arisen. Not only does it cover health and accident policies generally; it also deals specifically with accidental death coverages arising from these policies as well as prospective review procedures in said policies. Additionally, in any case where these coverages arise from employee benefit packages, the issue of ERISA [Employee Retirement Income Security Act, 29 U.S.C. 1144 (a)] preemption must be considered. See e.g. Coles v. Metropolitan Life Insurance Co., 837 Fed. Sup. 764 (M.D.La. 1993); Cramer v. Association Life Insurance Company, 569 So.2d 533 (La. 1990); W.McKenzie and H.Johnson, 15 La. Civil Law Treatise, Insurance Law Practice § 297 (1986).

**1. Who has the right to make the claim?**

The insured is the only person with the right to make the claim for penalties and attorneys fees on a health and accident policy. See e.g. Jefferson Oncology v. Louisiana Health Services and Indemnity Co., *supra*. However, this would not make sense with claims for accidental death under LSA-R.S.22:657(B), just as in the case of death claims under LSA-R.S.22:656. The beneficiary would be the appropriate claimant. At least one older case, dealing with the predecessor statute, has said that the heirs of the beneficiary are not proper claimants. Canal-Commercial Trust and Savings Bank v. Employers Liability Assurance Corporation of London, England, 155 La. 720, 99 So. 542 (1924).

**2. Who has exposure to the claim?**

As mentioned above, there are three distinct types of claims dealt with in this section arising from health and accident policies:

- 1) General claims under health and accident policies under subsection A;
- 2) Claims for accidental death arising under health and accident policies under subsection B; and
- 3) Claims involving prospective review under subsection D.

Who has exposure differs depending upon which type claim is made.

In the first two instances, general claims under subsection A and accidental death claims under subsection B, the statute makes the insurer the entity with the exposure, just as LSA-R.S.22:656. See Dupuis v. Tiger Oil Int'l, Inc. 444 So.2d

1379 (3rd Cir. 1984). It should be noted though that the Patient's Compensation Fund is not an insurer under either LSA-R.S.22:657 or 658. Lamark v. NME Hospitals, Inc. 542 So.2d 753 (4th Cir. 1989). However, subsection C further provides that anyone, including the State, who provides or contracts to provide health and accident benefits coverage as a self-insurer is subject to the provisions of this section including penalties and attorney's fees. An exception is made for collectively bargained union welfare plans other than health and accident plans. Thus, more than insurers are involved.

In prospective review cases under subsection D, the statute broadens exposure. Not only can an insurer or self-insurer have exposure, but also a third party administrator or other independent contractor can be found liable as well.

### **3. What are the elements of the claim?**

Again, there are three distinct types of claims covered in LSA-R.S.22:657. Thus, there are three separate and distinct proof elements to support these claims. In all claims, however, the suit for penalties and attorney's fees must be brought within one year from the date proofs of loss are required to be filed. LSA-R.S.22:657(C).

For claims arising under subsection A, the elements are as follows:

- a) A health and accident contract issued in this state;
- b) Written notice that proof of claim in the form required by the terms of the policy;
- c) Failure to pay within 30 days of receipt of notice and proof of claim; and
- d) Lack of just and reasonable grounds such as would put a prudent businessman on his guard for the failure to pay.

Additionally, payment must be made at least every 30 days during the period of disability for disability coverage provisions.

While the statute seems to require a proof of claim in the form required by the policy, the jurisprudence has not been so strict. An insurer who receives actual notice of the claim and refuses to pay will be liable even though proof of loss forms were not received. Humphries v. Puritan Life Insurance Co., 311 So.2d 534 (3rd Cir. 1975).

The courts have looked at "just and reasonable grounds, such as would put a prudent businessman on his guard", in a number of factual situations including

misrepresentation and fraud - Burt v. Combined Insurance Co. Of America, 428 So.2d 1023 (1st Cir. 1983); attempted cancellation of the policy - Breland v. All American Assurance Company, 366 So.2d 1051 (1st Cir. 1978); preexisting conditions - Nickels v. Guarantee Trust Life Insurance Co., 563 So.2d 924 (1st Cir. 1990); and, necessity of treatment, - Carmouche v. CNA Insurance Companies, 535 So.2d 1279 (3rd Cir. 1988) among others. Essentially, the question is whether or not the insurer had a reasonable basis for its failure to timely pay. Soniat v. Travelers Insurance Co., 538 So.2d 210 (La. 1989) This is a question of fact to be determined from the circumstances of the case in question. Landry v. Louisiana Hospital Service, Inc., 449 So.2d 584 (1st Cir. 1984).

For claims arising under subsection B, the elements are the same as under LSA-R.S.22:656 except that the latter are claims for accidental death arising under health and accident policies. There is another possible distinction. LSA-R.S.22:656 applies to actions arising under policies of insurance issued or delivered within this state. LSA-R.S.22:657 is more confusing. Subsection B is silent as to either issuance or delivery. Subsection A deals with all claims arising under health and accident policies issued in this state, except as provided in subsection B. Accordingly, the argument can logically be made that subsection B covers all health and accident contracts over which Louisiana can exercise jurisdiction in compliance with due process. More likely, the subsection will be read "*in pari materia*" with subsection A so as to be limited to policies issued in this state.

For claims arising under subsection D, the elements are as follows:

- a) A contract issued or delivered in this state;
- b) A provision in non-emergency cases requiring prospective evaluation prior to the delivery of health care; and
- c) Unreasonable delay, reduction or denial of medically necessary services or care.

"Emergency" is defined as a physical condition which places the insured in imminent danger of death or permanent disability as certified and determined by the attending physician in his medical judgment. The subsection also provides definitions for "unreasonable delay", "unreasonable reduction", "unreasonable denial", and "medically necessary treatment or care". Interestingly, the provisions defining unreasonable reduction and denial as well as medically necessary treatment or care are mandatory (i.e. "shall mean"); whereas, unreasonable delay is not so defined. Rather, the subsection provides that "two working days" is 'per se' reasonable while a period in excess of two working days "may be considered unreasonable depending on the

circumstances of the case”.

#### **4. What damages and/or penalties are recoverable?**

As with all other aspects of this Section, there are three distinct sets of damages and/or penalties recoverable, depending on the subsection involved.

Under subsection A, the penalty is double the amount of the benefits due plus attorneys fees to be determined by the court. While this could logically be read to allow recovery of benefits plus a penalty of double the benefits such that the recovery is three times the amount of the benefit, the courts have refused to do so. See Fulton v. Blue Cross of Louisiana, 563 So.2d 492 (4th Cir. 1990); Bischoff v. Old Southern Life Insurance Co., 502 So.2d 181 (3rd Cir. 1987); and Matherne v. Aetna Life and Casualty Insurance Co., 484 So.2d 740 (1st Cir. 1986). But see Bonura v. United Bankers Life Insurance Co., 562 So.2d 181 (3rd Cir. 1989) and Carmouche v. CNA Insurance Companies, *supra*.

Under subsection B, the penalty is similar to LSA-R.S.22:656 except that the interest rate is 6% per annum instead of 8% pre annum. Apparently when section 656 was amended in 1980 to increase the amount of the penalty to 8%, this subsection was overlooked.

It has been accepted that no attorneys fees are due under subsection B, just as in the case of LSA-R.S.22:656 (See W. McKenzie and H. Johnson, 15 La. Civil Law Treatise, Insurance Law and Practice, Section 293 (1986)). However, the statutory language is loose enough to make an argument that fees can be recovered in addition to the penalty. Subsection A deals with all claims under the terms of health and accident policies issued in this state, except as provided in subsection B. It further provides that failure to comply with the provisions of this Section shall subject the insured to double benefits plus attorney's fees. Subsection B of Section 657 is silent as to attorney's fees although it is clear as to the penalty. Because of the nature of the policy, it does change the actual penalty for those types of death claims from the penalty under health and accident policies generally. However, because the language allowing attorney's fees speaks in terms of the provisions of the Section as opposed to the subsection, the argument can be made that it is only the penalty part of subsection B which is different from subsection A and not a provision regarding attorneys fees. One should beware of strict construction as mentioned above.

Under subsection D, the insurer is entitled to damages limited “solely to the physical injuries which are the direct and proximate cause of the unreasonable delay,

reduction or denial” together with reasonable attorney’s fees and court costs. Despite this sloppy language, the statute was probably intended to allow recovery for physical injuries directly and proximately caused by the unreasonable action. There is also an unresolved question of what is meant by “physical injuries”.

**C. 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 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 therefore, as provided in R.S.22:658(A)(1), or within thirty days after written agreement or

settlement as provided in R.S.22:658(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 ten 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, together with all reasonable attorney fees for the prosecution and collection of such loss, or in the event a partial payment of tender has been made, ten percent of the difference between the amount paid or tendered and the amount found to be due and all reasonable attorney fees for the prosecution and collection of such amount.

(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.22:1173<sup>2</sup>, 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.

This statute was originally the catch-all statute designed to deal with all types of policies other than life, health and accident and later workers' compensation. This

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R.S.22:1173 was repealed by Acts. 1993, No. 952, § 5, eff. Jan. 1, 1994. See now R.S.22:1115.

statute has also been significantly amended to address specific abuses which caught the legislative “eye”. The statute now covers not only the insurer’s duty to timely pay the insured, but also includes duties to third parties to pay property damage and medical claims, duties to initiate loss adjustment, duties to make written settlement offers on property damage claims, method of payment provisions and special rules for arson claims, personal vehicle loss of use, and motor vehicle repairs. There is substantial overlap between this statute and LSA-R.S.22:1220. In fact, the courts look to LSA-R.S.22:658 for guidance in the application of section 1220. Harris v. Fontenot, 606 So.2d 72 (3rd Cir. 1992).

### **1. Who has the right to make the claim?**

There is jurisprudential dicta that LSA-R.S.22:658 duties apply only to the insured. Harris v. Fontenot, *supra*. While this was true at one time, it is not true now. Because there are numerous factual situations covered by Section 658, there are differing rules regarding whom has the right to sue.

The distinct types of claims under Section 658 are as follows:

- 1) The insurer’s duty to pay claims of the insured [Subsection A(1)];
- 2) The insurer’s duty to pay property damage and medical expense claims of a third party claimant after a written settlement agreement [Subsection A(2)];
- 3) The insurer’s duty to initiate loss adjustment of property damage and medical expense claims after notice of loss [Subsection A(3)];
- 4) The insurer’s duty to make a written offer to settle property damage claims after proof of loss [Subsection A(4)];
- 5) Method of claims payment restrictions [Subsection C(1-3)];
- 6) Personal vehicle property damage claims [Subsection B(4)]; and
- 7) Restrictions in motor vehicle repair conditions payment [Subsection D].

However, as there are no penalty provisions related to a failure to make a written offer to settle property damage claims within thirty days of satisfactory proof of loss, no further discussion thereof is needed.

To summarize, duties are either owed to the insured, third party claimants, or simply any claimant. The general duty under subsection A(1) is owed only to the insured. The duties under subsection A(2) involving property damage and medical expense after written settlement as well as the duties under subsection B(4) involving

personal vehicle property damage loss of use claims are owed only to third parties. The duties to initiate loss adjustment under subsection A(3), the method of payment restrictions under subsection C as well as the restrictions in motor vehicle repair conditions to payment in subsection D are owed to all claimants.

Because there is no limitation in the types of damage claims brought under the contracts covered by Section 658, subsection A(1) has the broadest application. Insureds under automobile policies (including uninsured motorist coverage), commercial general liability policies, owner landlord tenant policies, and homeowner's policies have the right to seek penalties and attorney's fees. However, the claim must be made as an insured. Thus, when a named insured brought suit against his insurer for injuries suffered as a guest passenger, he was not entitled to penalties and attorneys fees under LSA-R.S.22:658(A)(1) because he was suing as a third party claimant. Nettleton v. Audubon Insurance Co., *supra*.

## **2. Who has the exposure to the claim?**

In all instances under LSA-R.S.22:658, the insurer is the entity with exposure to penalties and attorneys fees. This is particularly important here. Many claims which would fall under this Section do not because the defendant is not an insurer. The Patient's Compensation Fund is not an insurer. Lamark v. NME Hospitals, Inc. *supra*. Louisiana Insurance Guaranty Association (LIGA) is not an insurer. Williams v. Champion Insurance Co., 590 So.2d 736 (3rd Cir. 1991). Similarly, neither is the State, political subdivisions thereof, self-insureds and third party administrators. None of these entities are covered by the definition of insurer.

## **3. What are the elements of the claim?**

Given that there are six distinct types of claims for penalties under Section 658, it follows that there are six different sets of proof elements for recovery of penalties and attorneys fees. To complicate matters further, where claims are made for failure to timely pay under subsection A(1) or A(2) in cases involving arson, the time provisions for payment are suspended until certification by the state fire marshal or other state or local investigative bodies that there is either no evidence of arson or that there is insufficient evidence to warrant further proceedings. LSA-R.S.22:658(B)(2).

For claims arising under subsection A(1), the elements are as follows:

- a) Receipt of satisfactory proof of loss;

- b) No payment within thirty days of receipt; and
- c) Failure to pay is arbitrary, capricious or without probable cause.

Many of these claims, as well as the interpretive jurisprudence, arise from uninsured/underinsured motorist coverage cases. See e.g. McDill v. Utica Mutual Insurance Co., 475 So.2d 1085 (La. 1985); Hart v. Allstate Insurance Co., *supra*; and Khaled v. Windham, *supra*. However, the subsection covers claims under all types of policies covered by the Section. See e.g. Broussard v. National Union Fire Insurance Co. Of Louisiana, 653 So.2d 816 (3rd Cir. 1995); and Warner v. Liberty Mutual Fire Insurance Co., 543 So.2d 511 (4th Cir. 1989).

Satisfactory proof of loss has been defined as information sufficient to fully apprise the insurer of the insured's claim. McDill v. Utica Mutual Insurance Co., *supra*. However, once the insurer knows of the claim, it has an obligation to investigate. Hart v. Allstate Insurance Co., *supra*; Daney v. Haynes, 630 So.2d 949 (4th Cir. 1993). Proofs of loss are not required to be in any particular form and may even be verbal. Riverland Oil Mill, Inc. v. Underwriters of Lloyds, New York, 368 So.2d 156 (2nd Cir. 1979).

In determining whether payment was made, the courts have required an unconditional tender of the reasonable amount that is due (i.e. an amount over which reasonable minds could not differ). Khaled v. Windham, *supra*, citing McDill v. Utica Mutual Insurance Co., *supra*. A settlement offer, or an offer to tender, is not sufficient; an actual tender of funds must be made. *Id.*

"Arbitrary, capricious or without probable cause" has been held synonymous with common law "vexatious refusal to pay" which means an unjustified refusal or one without reasonable or probable cause or excuse. Louisiana Maintenance Service, Inc. v. Certain Underwriters at Lloyds of London, 616 So.2d 1250 (La. 1993). Both terms describe an insurer whose willful refusal to pay is not based on a good faith defense. *Id.*

For claims arising under subsection A(2) the elements are as follows:

- a) A written agreement of settlement;
- b) Property damage or medical expense claim;
- c) No payment within thirty days of the written agreement; and
- d) The failure to pay is arbitrary, capricious or without probable cause.

This seems to be fairly straight forward. There are little or no interpretive cases.

However, as is mentioned later under LSA-R.S.22:1220; it is not clear whether “written agreement of settlement” is synonymous with a binding compromise.

The arbitrary, capricious or without probable cause provisions should be interpreted in the same manner as under subsection A. However, the subsection does contain some puzzling language. The insurer is to pay “any third party...claim due any bona fide third party claimant within thirty days after written settlement...from any third party claimant”. Why the requirement of a “bona fide” claimant when there is a written settlement?

For claims arising out of subsection A(3), the elements are as follows:

- a) A property damage or medical expense claim;
- b) Notification of loss by claimant;
- c) Failure to initiate loss adjustment; and
- d) Lapse of thirty days for a catastrophic loss and fourteen days for a non-catastrophic property loss.

There are very few cases which even mention this subsection, much less interpret it. There are no definitions for “initiation of loss adjustment” nor for “catastrophic loss”. It at least can be argued that notification of loss is no more restrictive than “satisfactory proof of loss” under previous statutes.

For claims arising under subsection B(4) the elements are as follows:

- a) Property damage claim on a personal vehicle;
- b) Loss of use of said vehicle for more than five working days;
- c) Loss is a direct consequence of the inaction of the insurer;
- d) Failure to pay reasonable expenses in obtaining alternative transportation for the entire period of the loss;
- e) Lapse of thirty days after receipt of adequate written proof and demand therefor; and
- f) Failure to pay was arbitrary, capricious or without probable cause.

Again, there really are no interpretive cases. What “direct consequence” or “adequate written proof” actually are must wait for another day.

For claims arising under subsection C, the elements are as follows:

- a) Failure to pay the claim by check or draft of the insurer to the claimant,

his attorney or assignee; or

b) Intentional or unreasonable delay (for more than three calendar days excluding Saturdays, Sundays and legal holidays) of the processing of a properly executed settlement check or draft after presentation for collection.

There is no jurisprudence interpreting this subsection. Most cases which cite this subsection do so because of the applicability of its penalty provisions for wrongful failure to pay workers' compensation benefits.

Finally, for claims under subsection D, the claimant must simply prove that the insurer conditioned payment of a claim on repairs being made by a particular entity or in a particular place or shop. Again, there is no interpretive jurisprudence.

#### **4. What damages and/or penalties are recoverable?**

As with other aspects of this statute, the differing types of claims give rise to different damages and/or penalties. There are five different penalty provisions.

Under subsections A(1) and A(2) a penalty of 10% in the amount due or \$1,000, whichever is greater, as well as reasonable attorney's fees are recoverable in addition to the amount of the loss. When there is a tender, the penalty is 10% of the difference between the tender and the amount ultimately found due as well as reasonable attorney's fees.

Under subsection (A)(3), the penalties are those as provided in LSA-R.S.22:1220. These will be discussed hereinafter.

Under subsection (B)(4), the penalty is also in addition to the amount of reasonable expenses incurred in obtaining alternative transportation. It shall be a reasonable penalty, not to exceed 10% of those reasonable expenses or \$1,000, whichever is greater, together with reasonable attorney's fees.

Under subsection (C), the penalty is \$200 or 15% of the check or draft, whichever is greater. As mentioned above, this seems to be the workers' compensation penalty provision.

Under subsection (D), the penalty is a fine of not more than \$500 for each offense. Interestingly, the statute does not make clear to whom this "fine" is to be paid.

**D. 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. This Section shall not apply to industrial and burial insurance companies, as provided for in R.S.22:251 and 253 or to any insurer that markets under the Home Service Marketing distribution method and issues a majority of its policies on a weekly or monthly basis.

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.

This statute not only codified the law regarding the insurer's duty to the insured but also created new obligations in favor of third party claimants. Rusch v. Cook, 619 So.2d 122 (1st Cir. 1993). The effective date of the Act was July 6, 1990. However, its application to existing litigation has been subject to jurisprudential interpretation. The appellate courts have generally held the Act to be substantive legislation and therefore prospective in application only, with the date of the accident being determinative. Smith v. Audubon Insurance Co., 656 So.2d 11 (3rd Cir. 1995); Jeffries v. Estate of Pruitt, 638 So.2d 723 (1st Cir. 1994); and Rusch v. Cook, *supra*. Other cases have held that even when the actual breach of duty occurred after July 6, 1990, there was no retroactive application where the underlying occurrence was before July 6, 1990. See Tarver v. Eckstein, 633 So.2d 764 (5th Cir.1994.)

The Supreme Court in Manuel v. Louisiana Sheriff's Risk Management Fund, 664 So.2d 81 (La. 1995), adopted the Tarver view. The court had the opportunity to completely settle the issue but chose not to do so. While the court did find the statute to be remedial, that finding is of little help regarding retroactive application. See LSA-C.C.art. 6, comment (d). Still hanging is the issue of whether, in respect of a pre-July 6, 1990 occurrence, a pre-July 6, 1990 breach of duty under the statute will be covered.

### **1. Who has the right to make the claim?**

This question, until very recently, created substantial confusion. Subsection A of the statute created two separate duties: one of good faith and fair dealing, and one to adjust claims fairly and make a reasonable effort to settle. See e.g. Manuel v. Louisiana Sheriff's Risk Management Fund, *supra* at 88 (Marcus, J. concurring), Estate of Robichaux v. Jackson National Life Insurance Company, 821 Fed.Sup. 429 (E.D. La. 1993). Subsection B could be interpreted, as it was by some courts, to be an exclusive list of violations under the general duties set forth in subsection A. See e.g. Armstrong v. Rabito, 663 So.2d 512 (4th Cir. 1995); Hernandez v. Continental Casualty Co., 615 So.2d 484 (4th Cir. 1993); Levy v. Cummings, 631 So.2d 55 (2nd

Cir. 1994.) It was also interpreted to be merely illustrative. See e.g. D'Abreau v. Diesel Power International, Inc., 625 So.2d 540 (5th Cir. 1993).

On November 14, 1996, the Louisiana Supreme Court issued its opinion in Theriot v. Midland Risk Insurance Company, 95-2895 (La. 11/14/96), 1996 WL 666140 (La.) ("Theriot I") on writs from the Third Circuit. In a sweeping decision, criticized by Justice Marcus in a dissent, the majority held that Subsection 1220A imposed a duty upon an insurer to a third party claimant so as to grant the third party claimant the right to recover damages for the insurer's breach of the duty. The court interpreted Subsection 1220A to impose two duties upon an insurer: (1) a duty owed to its insured of good faith and fair dealing, applicable both to claims by the insured and to claims by a third party against the insured; and (2) a duty owed to both the insured and the claimant to adjust claims fairly and promptly and to make a reasonable effort to settle claims. In consequence, the court concluded that Subsection 1220C provided a third party claimant the right to recover penalties against a breaching insurer in addition to the damages authorized in Subsection 1220A resulting from the breach. The court further held that Subsection 1220B, setting forth certain enumerated acts or failures to act, was illustrative, rather than exclusive, and did not limit liability only to cases involving the breaches specified therein.

An application for rehearing was then granted and the case reargued. This time, in an opinion authored by Justice Marcus who had dissented from the original decision, the court seems to have gotten it right in an abrupt 180° turn. In Theriot v. Midland Risk Insurance Company, et al., 95-2895 (La. 5/20/97), 1997 WL 2612359 (La.), ("Theriot II"), the court held that the statute did in fact create a right of action directly in favor of third party claimants, but only in respect of the second sentence of Section A, i.e., the affirmative duty of an insurer to adjust claims fairly and promptly and to make a reasonable effort to settle claims. The duty set forth in the first sentence (the duty of good faith and fair dealing) only flows to the insured. The court also held that the five enumerated acts set forth in Section B are exclusive, not illustrative, and therefore an insurer's liability is limited only to cases involving the breaches specified therein. Putting these two pronouncements together, numbers 1 (misrepresenting pertinent facts or policy provisions relating to coverage), 2 (failure to pay a settlement within 30 days of a written agreement to do so) and 4 (misleading a claimant as to the applicable prescriptive period) obviously would apply to assured and third party claimants while number 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 assured) would apply to an assured and could potentially apply to a claim by a third party, and number 5 (failing to pay a claim due a person insured by the contract) would only apply to an insured, and not a third party claimant.

## **2. Who has the exposure to the claim?**

The statute clearly imposes the obligation on the insurer. Tarver v. Eckstein

Marine Service, Inc., *supra*. Thus, just as with LSA-R.S.22:658, there are a number of potential defendants who are not covered by the statute. (i.e. third party administrators and self-insureds)

Additionally, the statute excludes health and accident policies, industrial and burial insurance companies, or any insurer that markets under a Home Service Marketing distribution method and issues a majority of its policies on a weekly or monthly basis. LSA-R.S.22:1220 D & E. Further, the courts have held that due to the exclusive jurisdictional nature of the workers' compensation act; this statute does not apply to workers' compensation cases. Sneed v. Gilchrist, 619 So.2d 888 (3rd Cir. 1993); and Alford v. Travelers Insurance Co., 609 So.2d 906 (4th Cir. 1992). Finally, the statute specifically provides that LIGA shall not be liable for "special damages" awarded under this section. LSA-R.S.22:1220 F. Since the statute provides for "penalties" in addition to "any general or special damages"; does this provision now make LIGA responsible for penalties and general, but not special, damages under this statute?

### **3. What are the elements of the claim?**

Under the general duties set forth in subsection A, a claim can be made by the appropriate party by showing:

- a) breach of the duty to the assured of good faith and fair dealing; or
- b) breach of the affirmative duty owed to both the assured and third parties to adjust claims fairly and promptly and to make a reasonable effort to settle them.

There is technically still a conflict in the circuits as to whether it is necessary to suffer damage as a result of the breach before penalties are recoverable. **Pro:** Khaled v. Windham, *supra*; and Champagne v. Hartford Casualty Insurance Corporation, 607 So.2d 752 (1st Cir. 1992). **Con:** Hall v. State Farm Mutual Automobile Insurance Co., *supra*; and Midland Risk Insurance Company v. State Farm Mutual Automobile Insurance Co., *supra*. As Justice Marcus pointed out in his dissent in Theriot v. Midland Risk Insurance Company, *supra*, ("Theriot I"), the statute itself speaks in terms of penalties "in addition to general and special damages" such that penalties should not be imposed in the absence of damages. Without comment, the majority in Theriot I amended the judgment to strike the damage award but maintained the award of penalties. When the Supreme Court revisited the case in Theriot II, it reinstated the trial court's decision which allowed neither damages or penalties. It would appear that it could be opined that damages are necessary in order for the imposition of penalty under this section but same would only be implicit, rather than explicit.

There are no statutory definitions for "the duty of good faith and fair dealings", the "affirmative duty to adjust claims fairly and promptly", or "reasonable effort to settle

claims” as set forth in subsection A. However, as previously mentioned, the courts look to the basic statutes for guidance here. The courts will probably find “good faith and fair dealing,” “fair and prompt claims adjustment” and “reasonable effort to settle claims” as long as the insurer has a reasonable basis for its actions. See i.e. Louisiana Maintenance Services, Inc. v. Certain Underwriters at Lloyds of London, *supra*; and Soniat v. Travelers Insurance Co., *supra*. Such findings are questions of fact to be determined on a case by case basis. Landry v. Louisiana Hospital Service, Inc., *supra*; See also the discussion of LSA-R.S.22:1214 hereinbelow.

Some cases have stated that a party seeking penalties under Section 1220 has the burden of proving that the insurer arbitrarily and capriciously breached its duty of good faith and fair dealing. See Hall v. State Farm Mutual Automobile Insurance Co., *supra*. This is probably an overstatement. The cases have held that the insurer has an affirmative duty to investigate the claim. Daney v. Haynes, *supra*; and Perez v. Allstate Insurance Co., 625 So.2d 1067 (4th Cir. 1993).

The specific duties set forth in subsection B are fairly self-explanatory. Some issues do exist, however. It is important to note that the subsection requires a knowing violation. It is unclear as to whether “constructive knowledge” (i.e. should have known) will work its way into the statutory construction. The statute has been held to be a penal statute and therefore subject to strict construction. Clausen v. Fidelity and Deposit Company of Maryland, *supra*. On the other hand, Manuel v. Louisiana Sheriff’s Risk Management Fund, *supra*, found the statute to be remedial. Thus, it can be liberally construed. See e.g. Guichard Drilling Company v. Alpine Energy Services, Inc., 657 So.2d 1307 (La. 1995). It seems doubtful that a defense of negligence will be allowed to defeat a claim for penalties herein. See e.g. LSA-R.S.22:1217.

Some other issues arise regarding specific subsection B violations. For example, in determining whether “pertinent facts or insurance policy provisions relating to coverage” are misrepresented, must such misrepresentation “materially” affect coverage or will any effect on coverage be sufficient? See e.g. LSA-R.S.22:619; Coleman v. Occidental Life Insurance Co., 418 So.2d 645 (La. 1982). With failure to pay a written settlement agreement within thirty days, must the agreement be binding under LSA-C.C.art. 3017? See e.g. Bennett v. The Great Atlantic & Pacific Tea Co., Inc., 665 So.2d 84 (1st Cir. 1995). If so, is an oral stipulation in open court on the record sufficient? See LSA-C.C.art. 3071; DeFazio v. City of Baton Rouge, *supra*.

Finally, most courts have held that these claims apply to pre- and post-litigation conduct (i.e. after suit is filed). DeFazio v. City of Baton Rouge, *supra*; and Harris v. Fontenot, *supra*. However, see Easterling v. Monroe City School Board, *supra*, where the court refused to apply the statute to a judgment albeit on somewhat different grounds. The court there found that there was no authority under Section 1220 for penalties for a failure to make timely payment of a judgment.

#### **4. What damage and/or penalties are recoverable?**

LSA-R.S.22:1220 A provides that “an insurer shall be liable for any damages sustained as a result of a breach of its duties therein.” LSA-R.S.22:1220 C provides that “in addition to any general and special damages”, the “claimant may be awarded penalties” not to exceed two times the amount sustained or \$5,000, whichever is greater”. Typically, the language raises a number of issues.

Given the treatment of “double the amount” of benefits due under LSA-R.S.22:657, one wonders whether “two times the damages sustained” means a double penalty in addition to the damages or simply an amount equal to the damages as the penalty. The Third Circuit, in Theriot v. Midland Risk Insurance Company, 664 So.2d 547 (3rd Cir. 1995), felt that the language “in addition to any general or special damages” was sufficiently clear to allow an award of damages plus a twice-damages penalty for a treble recovery and accordingly awarded \$3,000 in general damages and a penalty of \$6,000 in addition thereto. On appeal to the Supreme Court (Theriot I), the award of damages was stricken and the penalties reduced to \$3,000, with the court stating its belief that the situation presented was one in which the unreasonable insurer should be punished by an award of penalties rather than one in which an award of non-economic damages for mental anguish should be applied. On rehearing (Theriot II), the Supreme Court disallowed both damages and penalties. In consequence, while there is no extant jurisprudence allowing a penalty of twice the amount of damages, there is no definitive holding to the contrary.

The courts have also defined “any damages sustained by the breach”. A breach under subsection A renders the insurer liable for any damages, foreseeable or not, that are a direct consequence of its failure to perform. Williams v. Louisiana Indemnity Co., 658 So.2d 739 (3rd Cir. 1995). This leaves a lot of room for duty-risk analysis in determining the limits of damages due.

It should further be noted that the damages that are doubled to form the penalty are those sustained by the breach of duty under subsection A, not the amount claimed in the underlying lawsuit. Hall v. State Farm Mutual Automobile Insurance Co., *supra*. Further, the \$5,000 penalty is a per claimant limit and not a total limitation. *Id.* Finally, since the statute does not provide for attorney’s fees, such fees are not recoverable. *Id.*

#### **E. LSA-R.S.22:1213 Unfair methods and unfair or deceptive acts and practices prohibited**

No person shall engage in this state in any trade practice which is defined in this Part to be an unfair method of competition or an unfair or deceptive act or practice in the conduct of the business of insurance, including unauthorized insurance as provided in R.S.22:1249 et seq.

**LSA-R.S.22:1214**

**Methods, acts, and practices which are defined herein as unfair or deceptive**

The following are declared to be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

**(14) Unfair claims settlement practices.** Committing or performing with such frequency as to indicate a general business practice any of the following:

- (a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.
- (b) Failing to acknowledge and act 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) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds.
- (h) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.
- (i) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured.
- (j) Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made.
- (k) Making known to insureds or claimants a policy of

appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

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

(m) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

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

(o) Failing to provide forms necessary to present claims within fifteen calendar days of a request with reasonable explanations regarding their use, if the insurer maintains the forms for that purpose.

This statute reversed a longstanding specific exemption of insurance practices from the Unfair Trade Practices Act, LSA-R.S.51:1406. Under LSA-R.S.22:1217, the Commissioner of Insurance may determine after a hearing that a violation has occurred and may impose a penalty of not more than \$1,000 per violation up to a total of \$100,000. However, if the violator “knew or reasonably should have known” of the violation, the limits are \$25,000 per violation up to a total of \$250,000.

The courts have held that these statutes do not provide for a private cause of action, Clausen v. Fidelity and Deposit Company of Maryland, *supra*, but rather for regulation by the Commissioner of Insurance of such abuses. However, our courts have also held that “Criminal laws, traffic regulations, zoning laws, health laws, and others may and often do set the standard for lawful conduct and personal relationships, although they are designed for societal protection and incorporate practices and specific consequences for their breach”. Langlois v. Allied Chemical Corp., 258 La. 1067, 249 So.2d 133 (La. 1971). Violations of these standards may constitute fault and be a basis for civil liability under LSA-C.C.art.2315. Clomon v. Monroe City School Board, 572 So.2d 571 (La. 1990), and Boyer v. Johnson, 360 S.2d 1164 (La. 1978). However, they do not always do so. Gugliuzza v. KCMC, Inc., 660 So.2d 790 (La. 1992). The question is whether or not the statute is designed to protect a particular plaintiff from the type of harm that ensued. Laird v. Travelers Insurance Company, 263 La. 199, 267 So.2d

714 (La. 1972). An argument can be made that LSA-R.S.22:1213-1214 and particularly 1214(d) are designed to protect individuals harmed by the violation and, thus, a violation constitutes fault under LSA-C.C.art.2315. On the other hand, the requirement of “such frequency as to indicate a general business practice” is contraindicative of individual protection.

If a tort arises through these statutory violations, it is important to note that the violations can be committed by anyone, not just an insurer. LSA-R.S.22:1213 says, “no person” shall engage in unfair deceptive acts or practices. Furthermore, the specific types of practices that are prohibited are much broader than the previous statutes. Finally, even if violations under these statutes do not constitute “fault”, they still can provide a guide to the duty of good faith and fair dealing as well as the affirmative duty to adjust claims fairly and make reasonable settlement efforts under LSA-R.S.22:1220 A. See e.g. Harris v. Fontenot, *supra*.

#### **IV. CONCLUSION**

As can be seen from the above, the penalties provisions of the Insurance Code are not a model of legislative draftsmanship. There is overlap and conflict as well as sloppy draftsmanship. McKenzie and Johnson said it well:

“The legislature’s patchwork approach to solving perceived problems with the handling of claims of insurance companies aggravates and illustrates the need for comprehensive revision of the Insurance Code. Because the last comprehensive revision of the Insurance Code occurred in 1958, many areas of the Insurance Code have been plastered with a confusing array of legislative band-aids. As a result, the entire Code needs careful and coordinated study and treatment” 51 La. Law Review 253-254 (1990).

However, when statutes are poorly drafted, there is much room for legal maneuvering and creative lawyering. In six more years this area of the law will, doubtless, become the subject of clarifying decisions. Whether this will be good news to insurers is debatable.

## TABLE OF AUTHORITIES

Acts 1948, No. 195 .....	1
Alford v. Travelers Insurance Co., 609 So.2d 906 (La. App. 4th Cir. 1992).....	24
Armstrong v. Rabito, 95-0659, 95-0660 (La. App. 4th Cir. 10/26/95) 663 So.2d 512 .....	22
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Broussard v. National Union Fire Insurance Co. Of Louisiana, 94-1445 (La. App. 3rd Cir. 4/5/95) 653 So.2d 816 .....	18
Burt v. Combined Insurance Co. Of America, 428 So.2d 1023 (La. App. 1st Cir. 1983) .....	10
Canal-Commercial Trust and Savings Bank v. Employers Liability Assurance Corporation of London, England, 155 La. 720, 99 So. 542 (La. 1924).....	9
Carmouche v. CNA Insurance Companies, 535 So.2d 1279 (La. App. 3rd Cir. 1988) .....	11, 12
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Champagne v. Hartford Casualty Insurance Corporation, 607 So.2d 752 (La. App. 1st Cir. 1992) .....	24
Clausen v. Fidelity and Deposit Co. Of Maryland, 95-0504 (La. App. 1st Cir. 8/4/95) 660 So.2d 83 .....	2, 25, 29
Clomon v. Monroe City School Board,. 572 So.2d 571 (La. 1990).....	29
Coleman v. Occidental Life Insurance Co., 418 So.2d 645 (La. 1982).....	26
Coles v. Metropolitan Life Insurance Co., 837 Fed. Sup. 764 (M.D. La. 1993) .....	9
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Fulton v. Blue Cross of Louisiana, 563 So.2d 492 (La. App. 4th Cir. 1990).....	12
Gugliuzza v. KCMC, Inc. 606 So.2d 790 (La. 1992).....	29
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Landry v. Louisiana Hospital Service, Inc. 449 So.2d 584 (La. App. 1st Cir. 1984) .....	11, 24
Langlois v. Allied Chemical Corp., 258 La. 1067, 249 So.2d 133 (1971).....	29
Levy v. Cummings, 25,475 (La. App. 2nd Cir. 1/19/94) 631 So.2d 55 .....	22
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McDill v. Utica Mutual Insurance Co. 475 So.2d 1085 (La. 1985).....	18
Midland Risk Insurance Co. v. State Farm Mutual Automobile Insurance Co., 93-1611 (La. App. 3rd Cir. 9/21/94) 643 So.2d 242.....	24
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Perez v. Allstate Insurance Co., 625 So.2d 1067 (La. App. 4th Cir. 1993).....	25
Planned Investments, Inc. v. Brumfield, 319 So.2d 859 (La. App. 1st Cir. 1975) .....	2, 3, 5
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Smith v. Audubon Insurance Co. 94-1571 (La. App. 3rd Cir. 5/3/95) 656 So.2d 11 .....	22

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Theriot v. Midland Risk Insurance Co., 95-227 (La. App. 3rd Cir. 11/2/95) 664 So.2d 547, writ granted 95-2895 (La. 2/2/96) 666 So.2d 1095 .....	26
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Toups v. Equitable Life Assurance Co., 94-1232 (La. App. 3rd Cir. 5/3/95) 657 So.2d 142 .....	4
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W.McKenzie and H.Johnson, 15 La. Civil Law Treatise, Insurance Law Practice § 297 (1986).....	9, 12, 29
Warner v. Liberty Mutual Fire Insurance Co., 543 So.2d 511 (La. App. 4th Cir. 1989).....	18
Williams v. Champion Insurance Co., 590 So.2d 736 (La. App. 3rd Cir. 1991) .....	17
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Willis v. Willis, 287 So.2d 642 (La. App. 3rd Cir. 1973) .....	5