INSURANCE BAD FAITH LAW AND PRACTICE

By: Robert E. Kleinpeter
LAJ Last Chance CLE Conference 12/12/2019

I. Introduction

Insurance is a specialized type of contract designed to protect against financial loss. It is subject to the Civil Code's rules on interpretation. An insurance policy's terms may also be limited by statutory or public policy considerations because the relationship between most insured persons and insurance companies is wildly unequal. When an insurance company treats an insured—and in limited circumstances even a third party—unfairly, the legislature has prescribed penalties and damages in the Insurance Code, and sometimes, attorney fees.

II. Bad Faith Statutes

Most insurance disputes involve La. R.S. §§ 22:1892 and 1973. Other statutes address life (§ 1811), health and accident (§ 1821), and immovable property (§ 1893) coverages. The referenced statutory sections are attached as Exhibits 1–5. Note: the legislature renumbered the Insurance Code, effective January 1, 2009, but no substantive changes occurred. For example, former La. R.S. § 22:658 is now La. R.S. § 22:1892, and former La. R.S. § 22:1220 is now La. R.S. § 22:1973.

When analyzing the bad faith statutes, it's critical to determine the status of the litigant bringing the action. That's because the relationship between the insurer and its first-party insured is contractual, while the relationship between the insurer

and a third-party claimant is adversarial. Third-party penalties against the insurer are available in only a few instances.

Sections 1892 and 1973 have similar provisions, but there are significant differences. For example, La. R.S. § 22:1892(A)(1) requires an insurance company to pay the uncontested amount of a covered loss to its insured within 30 days after receiving satisfactory proof of the loss; whereas, La. R.S. § 22:1973(B)(5) requires an insurance company to pay the amount of any claim due a person insured under the contract within 60 days of receipt of satisfactory proof of the loss. And both statutes under § 1892(B)(1) and § 1973(B)(5) and (6) penalize the failure to timely pay a claim after receiving satisfactory proof of loss when that failure to pay is arbitrary, capricious, or without probable cause. Thus, the same conduct can be penalized under either of the two statutes, but, as explained below, the statutes offer different remedies.

III. Statutory Analysis

A. *Arbitrary, Capricious, or Without Probable Cause*

The Louisiana Supreme Court noted,

> [T]he New Oxford English American Dictionary defines an "arbitrary" act as one "based on random choice or personal whim, rather than reason or system," and capricious as "given to sudden and unaccountable changes in behavior." The phrase "arbitrary, capricious, or without probable cause" is synonymous with "vexatious," and a "vexatious refusal to pay" means "unjustified, without reasonable or probable cause or excuse." Both phrases describe an insurer whose willful refusal of a claim is not based on a good-faith defense.

Louisiana Bag Company, Inc. v. Audubon Indemnity Co., 08-0453 (La. 12/2/08), 999 So. 2d 1104, 1114 (internal citations omitted).

Only La. R.S. § 22:1892(A)(1), (2), and (4) (through La. R.S. § 22:1892(B)(1)) and La. R.S. § 22:1973(B)(5) and (6) (by their terms) require that the insurer's conduct meet the "arbitrary, capricious, or without probable cause standard" in order to impose the prescribed penalties.

B. *Other Bad Faith Conduct*

An insurer can be penalized in other statutory instances if that conduct was done knowingly, even if not "arbitrary, capricious, or without probable cause." *Sultana Corp. v. Jewelers Mut. Ins. Co.*, 03-0360 (La. 12/3/03), 860 So. 2d 1112, 1119; La. R.S. § 22:1973(B)(1–4).

C. *Good Faith Disputes*

If there are reasonable and legitimate disputes over liability or the extent of the loss, the failure to pay is not arbitrary, capricious, or without probable cause. "In sum, an insurer need not pay a disputed amount in a claim for which there are substantial, reasonable and legitimate questions as to the extent of the insurer's liability or of the insured's loss." *Louisiana Bag Company,* 999 So. 2d at 1116.

D. *State of Mind*

The insured doesn't need to prove specific acts or the insurer's state of mind in order to recover statutory penalties.

> [P]roof of specific acts or proof of the insurer's state of mind is generally not required to establish conduct that is arbitrary, capricious or without probable cause. A review of the applicable jurisprudence illustrates that it is "sufficient that the vexatious character of the insurer's refusal to pay can reasonably be found from a general survey of all the facts in evidence, specific evidence thereof not being necessary." "That is to say, direct and positive evidence of vexatious refusal is not necessary to impose the statutory penalty."

Louisiana Bag Company, 999 So. 2d at 1121–22 (internal citations omitted).

E. *Satisfactory Proof of Loss*

An insured does not have to fill out the insurer's prescribed form(s) to fully inform the insurer about the claim. It is well settled that "satisfactory proof of loss" is simply proof "sufficient to fully apprise the insurer of the insured's claims." *Louisiana Bag Company,* 999 So. 2d at 1119 (internal citations omitted). Proof of loss is a "flexible requirement to advise an insurer of the facts of the claim;" it need not be in any formal style or form. *Id.*

F. *Unconditional Tender*

An insurance company cannot delay payment because the insured is unable to prove the exact amount of a loss. The insurer must pay the undisputed damages by unconditional tender. An insurer must pay any undisputed amount over which reasonable minds could not differ. Failure to do so is considered, by definition, arbitrary, capricious, or without probable cause, and subjects the insurer to penalties on the difference between the amount paid/tendered and the amount found to be due. *Louisiana Bag Company*, 999 So. 2d at 1116.

G. *Disputes Over Insurance Policy Provisions*

If an insurer challenges coverage under its policy, it risks triggering statutory penalties. The Supreme Court has held, on multiple occasions, that an insurer "must take the risk of misinterpreting its policy provisions," and if an insurer "errs in interpreting its own insurance contract, such error will not be considered as a reasonable ground for delaying payment of benefits, and it will not relieve the insurer

of the payment of penalties and attorney's fees." *Louisiana Bag Company*, 999 So. 2d at 1117. Insurers are charged with knowledge of their policy's content and should not interpret their policy provisions at the expense of the insured. *Id.*

But Louisiana's Third Circuit has held that if the coverage issue is based on a factual, not legal dispute, the insurer can contest coverage without suffering statutory penalties. *Maxey v. Universal Cas. Co.*, 11-339 (La. App. 3d Cir. 10/5/11), 74 So. 3d 302.

The U.S. Fifth Circuit, in spite of *Louisiana Bag Company*'s holding, has opined that "it is not apparent from the statute that the Louisiana legislature intended insurers to pay penalties whenever they err in their interpretation of coverage." *Seacor Holdings, Inc. v. Commonwealth Ins. Co.*, 635 F.3d 675, 685 (5th Cir. 2011).

H. *Payment of Written Settlement Agreements*

Both § 1892(A)(2) and § 1973(B)(2) require an insurer to pay a written settlement amount within 30 days after execution of the written agreement. But the provisions differ in regard to whom they owe a duty and the standard of conduct required for imposition of statutory penalties.

Section 1892(A)(2) applies *only* to an insurer's written settlements with third-party claimants "to 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." Section 1973(B)(2) requires an insurer to pay a written settlement within

30 days after it is executed. So, § 1973(B)(2) applies to all written settlements, for both insureds and claimants, and if an insurer's refusal to pay a written settlement within 30 days is "knowingly committed," the statutory penalties in § 1973(C) may be imposed.

I. *Oral Settlements in Court*

Whether an oral settlement in Court triggers an insurance company's obligation to pay within the statutorily prescribed times is uncertain. *Batson v. South. La. Medical Center,* 97-1382 (La. App. 1st Cir. 9/25/98), 724 So. 2d 782, 789, held that a settlement agreement was not reduced to a writing, even though it was recited in open court, until the transcription was entered into the record. The Third Circuit has held the requirement of reduction to writing was met by oral recitation of the agreement in open court on the record. *Fruge v. Classic Communications, Inc.,* 04-1348 (La. App. 3d Cir. 2/2/05), 893 So. 2d 222, 226. Note: La. Civ. Code art. 3072 states that "[a] compromise shall be made in writing or recited in open court, in which case the recitation shall be susceptible of being transcribed from the record of the proceedings."

J. *Written Settlement Offers*

Under § 1892(A)(4), an insurance company must make a written offer to settle a property damage claim, including a third-party claim, within 30 days of receipt of satisfactory proof of loss. The "arbitrary, capricious or without probable cause" standard applies. Section 1973 does not require an insurer to make a written settlement offer to a claimant.

K. *Initiate Loss Adjustment*

"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 the loss by the claimant." La. R.S. § 22:1892(A)(3). The time may be extended in cases involving catastrophic loss and government-declared disasters. Failure to initiate timely loss adjustment subjects an insurance company to § 1973(C) penalties. This duty means the insurer cannot merely open a file on the loss. It must take affirmative steps to evaluate the claim. *Hollier v. State Farm Mut. Auto Ins. Co.*, 01-0592 (La. App. 3d Cir. 10/31/01), 799 So. 2d 793, 797.

L. *Misrepresentations*

An insurer can be found liable under § 1973(B)(1) for misrepresenting pertinent facts or insurance policy provisions relating to coverage. The Louisiana Supreme Court examined this provision in depth and ruled that an insurer can be liable for either "misrepresenting pertinent facts," or "misrepresenting insurance policy provisions relating to any coverages at issue." Thus, misrepresentation of pertinent facts about issues other than insurance coverage will allow the trier of fact to impose statutory penalties. *Kelly v. State Farm Fire and Cas. Co.*, 14-1921 (La. 5/5/15), 169 So. 3d 328.

M. *Bad Faith Failure to Settle*

An insurer can be found liable to its insured for a bad faith failure to settle a claim under § 1973(A) even though the insurer never received a firm (specific)

settlement offer from the insured. *Kelly*, 169 So. 3d at 340–41. "The determination of good or bad faith in an insurer's deciding to proceed to trial involves the weighing of such factors, among others, as the probability of the insured's liability, the extent of the damages incurred by the claimant, the amount of the policy limits, the adequacy of the insurer's investigation, and the openness of communications between the insurer and the insured." *Smith v. Audubon Ins. Co.,* 95-2057 (La. 9/5/96), 679 So. 2d 372, 377.

N. *Assignment*

If an insurance company fails to settle a third-party claim in bad faith that results in an excess judgment against its insured, Louisiana Civil Code article 2642 permits the insured defendant (who was sued along with the insurer by the third party) to assign any causes of action to the third party. *Smith v. Citadel Ins. Co.*, 19-00052 (La. 10/22/19), 2019 WL 5445086 at *2.

O. *Prescription*

A first-party bad faith claim "arises as a result of the insured's contractual relationship with the insurer [and] it is subject to a 10-year prescriptive period." *Smith*, 2019 WL 5445086 at *1.

P. *Violation of Both Statutes*

If an insurer violates both § 1892 and § 1973, the insured cannot recover duplicate damages and penalties. But the insured may recover differing statutory damages, penalties, and attorney fees for the insurer's violations under the separate statutory sections. *Calogero v. Safeway Ins. Co. of Louisiana*, 99-1625 (La. 1/19/00),

753 So. 2d 170; *Leland v. Lafayette Ins. Co.*, 11-475 (La. App. 3d Cir. 11/9/11), 77 So. 3d 1078. So, mix and match, but no duplication of penalties.

Q. *Summary Judgment*

The determination of whether the insurer's refusal to pay timely is subject to penalty necessarily involves the consideration of factual issues, so summary judgment is "rarely appropriate for a determination based on subjective facts such as intent, motive, malice, knowledge, or good faith." *Merwin v. Spears*, 12-0946 (La. 6/22/12), 90 So. 3d 1041, 1042.

IV. Penalties, Damages, and Attorney Fees

Sections 1892 and 1973 allow different statutory penalties, damages, and attorney fees. Some subsections have mandatory penalties, and other subsections are discretionary. The insurer cannot use assessed penalties under the two statutes in its filings for rate setting.

A. *La. R.S. § 22:1892*

Following the 2005 hurricanes, effective August 15, 2006, the statute provides for a mandatory 50% penalty plus reasonable attorney fees and costs.

1. Penalty

> [Statutory violations] shall subject the insurer to a penalty, in addition to the amount of the loss, of fifty 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, fifty percent of the difference between the amount paid or tendered and the amount found to be due as well as reasonable attorney fees and costs.

La. R.S. § 22:1892(B)(1). An insurer need only fail to tender one undisputed portion of the claim to be subject to penalties. *Louisiana Bag Company*, 999 So. 2d at 1122.

2. Attorney Fees

Section 1892(B)(1) permits the insured's recovery of attorney fees associated with a statutory breach but not those of the litigation as a whole. *Arceneaux v. Amstar Corp.*, 10-2329 (La. 7/1/11), 66 So. 3d 438. The statute does not state how to calculate attorney fees, and the courts have varied widely in their approach. For example, the Louisiana Supreme Court allowed 40% against a UM insurer who never tendered any sum, which was the amount of the plaintiff attorney's contingency contract. *McDill v. Utica Mut. Ins. Co.*, 475 So. 2d 1085 (La. 1985). A one-third contingency fee has been allowed. *Leland v. Lafayette Ins. Co.*, 11-475 (La. App. 3d Cir. 11/9/11), 77 So. 3d 1078. Other cases have not calculated fees on a contingency basis. *LaHaye v. Allstate Ins. Co.*, 570 So. 2d 460 (La. App. 3d Cir. 1990); *Mamou Farm Services, Inc. v. Hudson Ins. Co.*, 488 So. 2d 259 (La. App. 3d Cir. 1986) (attorney fee of $22,500 on a loss of over $500,000); *Bohn v. Louisiana Farm Bureau Mut. Ins. Co.,* 482 So. 2d 843 (La. App. 2d Cir. 1986) ($70,000 recovery; attorney fee of $12,500).

3. Mandatory

Section 1892(B)(1) provides that the unreasonable failure to pay on time **shall** subject the insurer to the 50% penalty and attorney fees.

4. Damages

This statute mandates penalties and attorney fees but does not, by its language, provide for any special or general damages flowing directly from the

insurer's breach. See *Sher v. Lafayette Ins. Co.*, 07-2441 (La. 4/8/08), 988 So. 2d 186 and *Wegener v. Lafayette Ins. Co.*, 10-810 (La. 3/15/11), 60 So. 3d 1220 for a discussion on insurance contracts and mental anguish damages.

B. *La. R.S. § 22:1973*

This statute outlines a penalty which is discretionary and limited. The statute contains mandatory damages and also permits discretionary damages. Attorney fees are not allowed.

1. Damages

Section 1973(A) holds an insurer liable "for any damages sustained as a result of the breach" of its duties of (1) good faith and fair dealing, (2) to adjust claims fairly and promptly, and (3) to make a reasonable effort to settle claims. The last sentence states that "[a]ny insurer who breaches these duties *shall* be liable for any damages sustained as a result of the breach." These consequential damages include both pecuniary and non-pecuniary which can be considered in calculating statutory penalties.

Section 1973(A)'s mandatory award of any "damages sustained as a result of the breach" of the imposed duty refers only to the "damages sustained" in § 1973(C); therefore, damages and penalties must be calculated on consequential, not contractual, damages. *Durio v. Horace Mann Ins. Co.*, 11-0084 (La. 10/25/11), 74 So. 3d 1159, 1170.

Though the statute states "shall," it is ultimately the trier of fact's discretion to determine whether any damages were sustained, and if so, the amount. In order

to recover special damages, specific evidence of medical treatment is not required. *Wegener v. Lafayette Ins. Co.*, 10-810 (La. 3/15/11), 60 So. 3d 1220.

2. Penalty

Section 1973(C) provides that "[i]n 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." Accordingly, an insurer who violates § 1973(A) is liable for compensatory damages (general and special) and a discretionary statutory penalty of up to two times the amount of sustained damages or $5,000.

3. Attorney Fees

Section 1973 does not provide for attorney fees.

V. Emerging Issues

In the 2019 session by House Resolution No. 220, the Louisiana legislature requested that the Louisiana State Law Institute "study and make recommendations regarding the provisions of the Louisiana Insurance Code, comprising Title 22 of the Louisiana Revised Statutes of 1950, concerning payment of claims, penalties, and attorney fees under the Louisiana Insurance Code." HR No. 220 is attached as Exhibit 6.

West's Louisiana Statutes Annotated
Louisiana Revised Statutes
Title 22. Insurance Code (Refs & Annos)
Chapter 6. Payment of Claims (Refs & Annos)
Part III. Property and Casualty Insurance Claims Payments

LSA-R.S. 22:1892
Formerly cited as LA R.S. 22:658

§ 1892. Payment and adjustment of claims, policies other than life and health and accident; personal vehicle damage claims; extension of time to respond to claims during emergency or disaster; penalties; arson-related claims suspension

Effective: August 1, 2019
Currentness

A. (1) All insurers issuing any type of contract, other than those specified in R.S. 22:1811, 1821, 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. The insurer shall notify the insurance producer of record of all such payments for property damage claims made in accordance with this Paragraph.

(2) All insurers issuing any type of contract, other than those specified in R.S. 22:1811, R.S. 22:1821, 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 except that the commissioner may promulgate a rule for extending the time period for initiating a loss adjustment for damages arising from a presidentially declared emergency or disaster or a gubernatorially declared emergency or disaster up to an additional thirty days. Thereafter, only one additional extension of the period of time for initiating a loss adjustment may be allowed and must be approved by the Senate Committee on Insurance and the House Committee on Insurance, voting separately. Failure to comply with the provisions of this Paragraph shall subject the insurer to the penalties provided in R.S. 22:1973.

(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) of this Section, respectively, or failure to make such payment within thirty days after written agreement or settlement as provided in Paragraph (A)(2) of this Section 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 fifty percent damages on the amount found to be due from the insurer to the insured, or

EXHIBIT 1

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, fifty percent of the difference between the amount paid or tendered and the amount found to be due as well as reasonable attorney fees and costs. 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.

(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.

(5) When an insurance policy provides for the adjustment and settlement of first-party motor vehicle total losses on the basis of actual cash value or replacement with another of like kind and quality, and the insurer elects a cash settlement based on the actual cost to purchase a comparable motor vehicle, such costs shall be derived by using one of the following:

(a) A fair market value survey conducted using qualified retail automobile dealers in the local market area as resources. If there are no dealers in the local market area, the nearest reasonable market can be used.

(b) The retail cost as determined from a generally recognized used motor vehicle industry source; such as, an electronic database, if the valuation documents generated by the database are provided to the first-party claimant, or a guidebook that is available to the general public. If the insured demonstrates, by presenting two independent appraisals, based on measurable and discernable factors, including the vehicle's preloss condition, that the vehicle would have a higher cash value in the local market area than the value reflected in the source's database or the guidebook, the local market value shall be used in determining the actual cash value.

(c) A qualified expert appraiser selected and agreed upon by the insured and insurer. The appraiser shall produce a written nonbinding appraisal establishing the actual cash value of the vehicle's preloss condition.

(d) For the purposes of this Paragraph, local market area shall mean a reasonable distance surrounding the area where a motor vehicle is principally garaged, or the usual location of the vehicle covered by the policy.

C. (1) All claims brought by insureds, workers' compensation claimants, or third parties against an insurer shall be paid by check or draft of the insurer or, if offered by the insurer and the claimant requests, electronic transfer of funds 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 the claimant to one specified; however, 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. The 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 repairs be made to a motor vehicle, including window glass repairs or replacement, in a particular place or shop or by a particular entity.

(2) An insurer shall not recommend the use of a particular motor vehicle service or network of repair services without informing the insured or claimant that the insured or claimant is under no obligation to use the recommended repair service or network of repair services.

(3) An insurer shall not engage in any act or practice of intimidation, coercion, or threat to use a specified place of business for repair and replacement services.

(4) The commissioner may levy the following fines against any insurer that violates this Subsection:

(a) For a first offense, one thousand dollars.

(b) For a second offense within a twelve-month period, two thousand five hundred dollars.

(c) For a third or subsequent offense within a twelve-month period, five thousand dollars.

(5) A violation of this Subsection shall constitute an additional ground, under R.S. 22:1554, for the commissioner to refuse to issue a license or to suspend or revoke a license issued to any producer to sell insurance in this state.

Credits

Renumbered from R.S. 22:658 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1985, No. 778, § 1; Acts 1986, No. 132, § 1, eff. June 26, 1986; Acts 1988, No. 398, § 1; Acts 1989, No. 638, § 1; Acts 1990, No. 262, § 1, eff. July 4, 1990; Acts 1990, No. 955, § 1; Acts 1992, No. 879, § 1; Acts 1993, No. 163, § 1; Acts 1993, No. 585, § 1; Acts

2003, No. 790, § 1; Acts 2006, No. 404, § 1; Acts 2006, No. 813, § 1; Acts 2009, No. 488, § 1; Acts 2010, No. 1032, § 1; Acts 2012, No. 271, § 1; Acts 2018, No. 27, § 1; Acts 2019, No. 317, § 1.

LSA-R.S. 22:1892, LA R.S. 22:1892
Current through the 2019 Regular Session.

End of Document

West's Louisiana Statutes Annotated
Louisiana Revised Statutes
Title 22. Insurance Code (Refs & Annos)
Chapter 7. Fraud and Unfair Trade Practices (Refs & Annos)
Part IV. Unfair Trade Practices (Refs & Annos)

LSA-R.S. 22:1973
Formerly cited as LA R.S. 22:1220

§ 1973. Good faith duty; claims settlement practices; cause of action; penalties

Effective: August 1, 2012
Currentness

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 of this Section:

(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.

(6) Failing to pay claims pursuant to R.S. 22:1893 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.

EXHIBIT 2

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. 22:2051 et seq., shall not be liable for any special damages awarded under the provisions of this Section.

Credits

Renumbered from R.S. 22:1220 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 1990, No. 308, § 1, eff. July 6, 1990. Amended by Acts 2006, 1st Ex.Sess., No. 12, § 1, eff. Feb. 23, 2006; Acts 2012, No. 271, § 1.

LSA-R.S. 22:1973, LA R.S. 22:1973
Current through the 2019 Regular Session.

End of Document

West's Louisiana Statutes Annotated
Louisiana Revised Statutes
Title 22. Insurance Code (Refs & Annos)
Chapter 6. Payment of Claims (Refs & Annos)
Part I. Life Insurance Claims Payments

LSA-R.S. 22:1811
Formerly cited as LA R.S. 22:656

§ 1811. Payment of claims; life policies; penalty

Effective: January 1, 2009
Currentness

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.

Credits

Renumbered from R.S. 22:656 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1980, No. 477, § 1.

LSA-R.S. 22:1811, LA R.S. 22:1811
Current through the 2019 Regular Session.

End of Document

EXHIBIT 3

West's Louisiana Statutes Annotated
Louisiana Revised Statutes
Title 22. Insurance Code (Refs & Annos)
Chapter 6. Payment of Claims (Refs & Annos)
Part II. Health and Accident Insurance Claims Payments
Subpart A. Health and Accident Insurance Claims Payment--General Provisions

LSA-R.S. 22:1821
Formerly cited as LA R.S. 22:657

§ 1821. Payment of claims; health and accident policies; prospective review; penalties; self-insurers; telemedicine reimbursement by insurers

Effective: August 1, 2012
Currentness

A. All claims arising under the terms of health and accident contracts issued in this state, except as provided in Subsection B of this Section, 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 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; 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 that 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

EXHIBIT 4

time of the request for a prospective evaluation or review by the duly licensed health care provider, as provided in the contract; such 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) of this Paragraph 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. 22:1969.

(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 either of the following:

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

(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 do any of the following:

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

(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 (a) of this Paragraph.

(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.

(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.

(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, 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 limited benefit health insurance policies or contracts authorized to be issued in the state.

G. Repealed by Acts 1999, No. 1017, § 2, eff. July 9, 1999.

Credits

Renumbered from R.S. 22:657 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Acts 1958, No. 125. Amended by Acts 1960, No. 287, § 1; Acts 1979, No. 240, § 1; Acts 1985, No. 429, § 1; Acts 1989, No. 773, § 1, eff. Jan. 1, 1990; Acts 1990, No. 872, § 1, eff. July 25, 1990; Acts 1995, No. 391, § 1, eff. June 16, 1995; Acts 1997, No. 846, § 1, eff. July 10, 1997; Acts 1997, No. 1313, § 1. Amended by Acts 2010, No. 919, § 1, eff. Jan. 1, 2011; Acts 2012, No. 271, § 1.

LSA-R.S. 22:1821, LA R.S. 22:1821
Current through the 2019 Regular Session.

End of Document

West's Louisiana Statutes Annotated
Louisiana Revised Statutes
Title 22. Insurance Code (Refs & Annos)
Chapter 6. Payment of Claims (Refs & Annos)
Part III. Property and Casualty Insurance Claims Payments

LSA-R.S. 22:1893
Formerly cited as LA R.S. 22:658.2

§ 1893. Claims involving immovable property

Effective: January 1, 2009
Currentness

A. (1) No insurer shall use the floodwater mark on a covered structure without considering other evidence, when determining whether a loss is covered or not covered under a homeowners' insurance policy.

(2) No insurer shall use the fact that a home is removed or displaced from its foundation without considering other evidence, when determining whether a loss is covered or not covered under a homeowners' insurance policy.

B. If damage to immovable property is covered, in whole or in part, under the terms of the policy of insurance, the burden is on the insurer to establish an exclusion under the terms of the policy.

C. Any clause, condition, term, or other provision contained in any policy of insurance which alters or attempts to alter the burden on an insurer as provided in Subsection B of this Section shall be null and void and of no effect.

D. Any insurer determined to be in violation of the provisions of this Section shall be liable pursuant to R.S. 22:1973.

Credits
Renumbered from R.S. 22:658.2 by Acts 2008, No. 415, § 1, eff. Jan. 1, 2009. Added by Acts 2006, 1st Ex.Sess., No. 12, § 1, eff. Feb. 23, 2006.

LSA-R.S. 22:1893, LA R.S. 22:1893
Current through the 2019 Regular Session.

End of Document

EXHIBIT 5

ENROLLED

2019 Regular Session

HOUSE RESOLUTION NO. 220

BY REPRESENTATIVE GAROFALO

A RESOLUTION

To authorize and request the Louisiana State Law Institute to study and make recommendations regarding the provisions of the Louisiana Insurance Code, comprising Title 22 of the Louisiana Revised Statutes of 1950, concerning payment of claims, penalties, and attorney fees under the Louisiana Insurance Code.

WHEREAS, the subject and availability of insurance is of great interest and importance to the people and businesses of this state; and

WHEREAS, each year the legislature attempts to address insurance legislation concerning a myriad of proposals dealing with insurance, insurers, claims, regulations, and interrelated matters; and

WHEREAS, the purpose of Title 22 of the Louisiana Revised Statutes of 1950, known and cited as the Louisiana Insurance Code, is to regulate the insurance industry in all of its phases; and

WHEREAS, the purpose of the Louisiana State Law Institute is to promote and encourage the clarification and simplification of the law of Louisiana and its better adaptation to present social needs; to secure the better administration of justice; and to carry on scholarly legal research and scientific legal work; and

WHEREAS, the Louisiana Insurance Code contains several provisions that provide for causes of action and recovery of penalties or attorney fees, or both, from insurance companies; and

WHEREAS, these provisions of the Louisiana Insurance Code differ depending upon the nature or type of the underlying insurance policy at issue; and

EXHIBIT 6

WHEREAS, as amended, these provisions of the Louisiana Insurance Code appear to be inconsistent and require study and possible revision; and

WHEREAS, there is an overriding public need to carefully study and deliberate prior to recommending changes to the Louisiana Insurance Code to maintain the confidence of the public in the insurance industry, its products, and the regulatory agencies and departments of the state and their operation, independence, and reliability; and

WHEREAS, the study of the relevant provisions of the Louisiana Insurance Code and proposals for revisions or amendments would bring clarity and certainty to this important area of Louisiana's insurance laws.

THEREFORE, BE IT RESOLVED that the House of Representatives of the Legislature of Louisiana does hereby authorize and request the Louisiana State Law Institute to study the laws concerning the award of penalties and attorney fees under the provisions of the Louisiana Insurance Code and make recommendations to the legislature of proposed legislation.

BE IT FURTHER RESOLVED that the Louisiana State Law Institute shall submit a report detailing the results of its study and any proposed legislation to the Legislature of Louisiana no later than February 1, 2020.

BE IT FURTHER RESOLVED that a copy of this Resolution be transmitted to the president of the Louisiana State Law Institute.

SPEAKER OF THE HOUSE OF REPRESENTATIVES