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OVERVIEW OF GENERAL BAD FAITH PRINCIPLES -- LOUISIANA

Louisiana's current law of bad faith is embodied in two statutes, La. R.S. 22:1892 and La. R.S. 22:1973. Both statutes were renumbered beginning in 2009 and most of jurisprudence refers to them by their original numbers La. R.S. 22:658 and La. R.S. 22:1220.

LA. R.S. 22:1892

History

La. R.S. 22:1892 (formerly La. R.S. 22:658) originated in 1908 as a penalty applicable to fire insurers. The statute required payment to the insured within 60 days of presentation of satisfactory proof of loss and demand. If the insurer did not pay, it was subject to a 12% penalty plus reasonable attorneys fees. The statute was later expanded to apply to all types of insurance, save life, health and accident policies. The payment period, the amount of the penalty and the applicability of attorneys fees have varied over the years. The statute has survived repeated constitutional challenges. As the Louisiana Supreme Court succinctly observed in *Hammett v. Fire Ass'n of Philadelphia*, 160 So. 302 (La. 1935):

> We fail to see where the statute is oppressive, arbitrary, or confiscatory, when all it seeks to do is to compel the insurance company to pay a just and legal obligation within a reasonable period of time; *i.e.*, 60 days.

Current version

The current version, La. R.S. 22:1892, provides that the insurer must pay any claim due any insured within *30 days* after receipt of satisfactory proofs of loss. The field of potential beneficiaries of the penalty provisions has been expanded, so that now an insurer is required to make a written offer to settle any property damage claim, *including one brought by a third party*, within 30 days of satisfactory proof of loss.

Failure to make payment or an offer of settlement within 30 days as required now subjects an insurer to a penalty of *50%* of the amount due (with a minimum of $1,000) plus reasonable attorneys fees and costs, but only if the failure is found to be arbitrary, capricious or without probable cause.

In 1989 a seemingly innocuous provision was added to the statute requiring that an insurer initiate loss adjustment of property damage and medical expense claims within 14 days after notification of loss by the claimant, except in case of catastrophic loss. This was eventually clarified to set the time period for loss adjustment in case of catastrophic loss at 30 days and to provide that failure to comply subjected the insurer to the penalties provided by La. R.S. 22:1973 (formerly La. R.S. 22:1220).

Failure to timely initiate loss adjustment

The loss adjustment penalty sprang to life after Hurricanes Katrina and Rita. In *Oubre v. Louisiana Citizens Fair Plan*, No. 2011-0097, 2011 WL 6379956 (La. Dec. 16, 2011), the Louisiana Supreme Court reinstated a trial court judgment of over $92 million in favor of a class of homeowners whose post-hurricane property damage claims had not been promptly addressed by Louisiana Citizens Fair Plan, Louisiana's state-run insurer of last resort. The court held that the language of subsection (A)(3) of the statute, particularly its use of the word "shall," meant that an insurer *must* initiate loss adjustment within thirty days, and if the insurer does not, the imposition of a penalty is mandatory. The court particularly noted that there was no reference to good or bad faith in this particular part of the statute. The insurer's inaction alone triggered the penalty. Further, requiring proof of bad faith would interfere with the statute's goal of encouraging insurers to timely commence loss adjustment with their insureds. The court rejected the argument that the extreme circumstances of the hurricanes excused the delay. Specifically, the court noted that the delay for initiation of loss adjustment in non-catastrophic cases was 14 days, as opposed to the 30 days allowed in catastrophic cases. Accordingly, the statute already took into account the difference in circumstances when losses are caused by a major catastrophe.

In 2009, the Louisiana Legislature amended (A)(3) to allow the Commissioner of Insurance to extend the delay 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 60 days.

Arbitrary, capricious or without probable cause

A case from 2008 from the Louisiana Supreme Court sets a concerning precedent for insurers about the standards for bad faith: *Louisiana Bag Co., Inc. v. Audubon Indem. Co.*, 2008-0453 (La. 12/2/08), 999 So. 2d 1104. In *Louisiana Bag*, the insured's manufacturing plant and warehouse facilities were destroyed by fire. Early on, the adjuster informed the insurer that the loss would exceed policy limits, but questions remained about the type of coverage and the extent of the loss. The insurer made payment of full limits, less an advance, six months after the point in time when it was deemed the insurer had sufficient information to pay.

The Louisiana Supreme Court affirmed the intermediate court of appeals' decision that penalties were in order under the penalties statute then in effect, La. R.S. 22:658 (now 22:1892). The following are the essential holdings of the Louisiana Supreme Court's opinion:

- While an insurer need not tender payment for amounts that are reasonably in dispute, "there can be no good reason " – or no probable cause – for withholding an undisputed amount. Where there is a substantial, reasonable and legitimate dispute as to the extent or amount of the loss, the insurer can avoid the imposition of penalties only by unconditionally tendering the undisputed portion of the claim. An insurer cannot "stonewall" an insured simply because the insured is unable to prove the exact extent of his damages.
- 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. Therefore, The insurer cannot avoid the payment of penalties for delay in tendering payment

within the statutorily mandated time period by reason of its interpretation of the coverage afforded by its policy.

- A "satisfactory proof of loss" is only that which is "sufficient to fully apprise the insurer of the insured's claims." The proof of loss requirement is flexible. An insurer's requirement that it receive its form of proof of loss before payment is insufficient to create probable cause to delay payment. To permit an insurer to insist upon its own proof-of-loss form would frustrate the intent and purpose of La. R.S. § 22:658 because it would allow the insurer to be solely in control of when proof of loss is received.
- An insured need not identify any specific conduct by the insurer that was arbitrary, capricious or without probable cause. Proof 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.

It appears that the best grounds to avoid penalties would be to argue that the insurer had a good faith disagreement with the insured over the cause and the extent of the loss. Arguing that there was a dispute over the legal interpretation of the policy language will only work if you win that argument, according to *Louisiana Bag*.

LA. R.S. 22:1973

State of the law before enactment of La. R.S. 22:1973

La. R.S. 22:1973 (formerly La. R.S. 22:1220) is a relative newcomer in comparison to La. R.S. 22:1982, but many of the principles it embodies are not new. Long before the enactment of La. R.S. 22:1220, Louisiana case law recognized that an insurer owes a duty of good faith to its insured.

An important early case in establishing the duty of good faith is the Louisiana Supreme Court's decision in *Roberie v. Southern Farm Bureau Cas. Ins. Co.*, 194 So. 2d 713 (La. 1967). In that auto accident case, the insurer failed to inform the insured of a settlement demand by the plaintiff before trial. The insurer took the case to trial and a judgment in excess of policy limits was rendered. The insured then sued his insurer for the excess judgment. The Supreme Court found that the insurer was not in bad faith in

rejecting the settlement demand and taking the case to trial because liability was in some dispute. But more significantly, the Supreme Court found that the insurer did commit bad faith by failing to keep its insured informed of settlement negotiations:

> We agree with the Court of Appeal that there was no bad faith on the part of the Insurance Company in not compromising the claims filed against it in the Pitre case. It acted within the terms of its insurance contract in proceeding to trial, and, under the facts supra, its actions could not be considered arbitrary, i.e., it preferred litigation to compromise. However, the insured, Roberie, was kept in the dark; he was never apprised of the offers of compromise nor warned of his potential liability; he was ignored. He needed information and advice on the point of his potential liability, which he was not given by his representative, his insurer. A conflict of interest arose between the insurer and the insured. The insurer failed to discharge its duty towards its insured, thereby precluding any decisive action on his part. We find that the actions of Southern Farm Bureau Casualty Insurance Company towards Roberie were more than negligent; they were in bad faith and in utter disregard of Roberie's natural desire to protect himself from financial loss.

Id. at 115.

In *Pareti v. Sentry Indem. Co.*, 536 So. 2d 417 (La. 1988), the Louisiana Supreme Court discussed the parameters of the insurer's duty of good faith when paying out limits and terminating a defense. While the court held that under the facts and circumstances of the case the insurer had acted in good faith in settling, the court went on to explain:

> The concern that in some cases an insurer might attempt to circumvent its duty to defend the insured by making an "early escape" from the litigation is a valid one. However, in order to safeguard against the risk that insurance companies will enter inappropriate settlements in some cases, it is not necessary for us to void an unambiguous contractual provision. Instead, the protection afforded to insureds against this contingency is that in every case, the insurance company is held to a high fiduciary duty to discharge its policy obligations to its insured in good faith-including the duty to defend the insured against covered claims and to consider the interests

> of the insured in every settlement. See *Holtzclaw v. Falco*, 355 So. 2d 1279 (La. 1977); *Richard v. Southern Farm Bureau Cas. Ins. Co*., 254 La. 429, 223 So. 2d 858 (La. 1969); *Reichert v. Continental Ins. Co*., 290 So. 2d 730 (La. App. 1st Cir.), *writ denied* 294 So. 2d 545 (1974); *Younger v. Lumbermens Mutual Cas. Co.*, 174 So. 2d 672 (La. App. 3rd Cir.), *writ denied*, 247 La. 1086, 176 So. 2d 145 (1965).
>
> When multiple claims are filed against the insured that have the potential for exceeding the insurer's policy limits, the insurer must act in good faith and with due regard for the insured's best interest in considering whether to settle one or more of the claims. *Holtzclaw*, 355 So. 2d at 1279; *Richard*, 223 So. 2d at 858. An insurer which hastily enters a questionable settlement simply to avoid further defense obligations under the policy clearly is not acting in good faith and may be held liable for damages caused to its insured. *See Sutton Mutual Cas. Co. v. Rolph*, 109 N.H. 142, 244 A.2d 186, 188 (1968); *Lumbermen's Mutual Cas. Co. v. McCarthy*, 90 N.H. 320, 8 A.2d 750 (1939).

Id. at 423. And in addition:

> Further, any payment of the policy limits which does not release the insured from a pending claim (*e.g.*, unilateral tender of policy limits to the court, the claimant or the insured), even if sufficient to terminate the duty to defend under the wording of the policy involved, raises serious questions as to whether the insurer has discharged its policy obligations in good faith.

Id. at 424.

Current version

In 1990 the Louisiana Legislature enacted La. R.S. 22:1220 (now 22:1973). The statute has been amended numerous times. In its current version it now reads:

> **§ 1973. 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.
>
> (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.
>
> D. The provisions of this Section shall not be applicable to claims made under health and accident insurance policies.

Cases have held that La. R.S. 22:1973 did not take the place of existing law, but merely codified it and supplemented it. *See e.g.*, *Lafauci v. Jenkins*, 2001-2960 (La. App. 1 Cir. 1/15/03), 844 So. 2d 19, 30, *writ denied*, 2003-0498 (La. 4/25/03), 842 So. 2d 403;

Gourley v. Prudential Property and Cas. Ins. Co., 98-0934 (La. App. 1 Cir. 5/14/99), 734 So. 2d 940, 944-45, *writ denied*, 99-1777 (La. 10/8/99), 750 So. 2d 969.

Insureds and third parties

In *Theriot v. Midland Risk Ins. Co.*, 95-2895 (La. 5/20/97), 694 So. 2d 184, the Louisiana Supreme Court considered whether the statute applied to third parties or only to insureds. In *Theriot* the middle driver in a three-car accident sued the automobile insurers of preceding and following drivers after they refused to pay the full amount of her claim. The insurers answered and asserted 1) that the duties imposed by La. R.S. 22:1220 run only between the insurer and its insured and do not afford a cause of action to a third-party claimant; and alternatively 2) if a third-party claimant had a cause of action, it was limited to the specific breaches of duty listed in 22:1220(B).

The Supreme Court first concluded that although the first sentence of 22:1220(A) referred only to the insured and was "an outgrowth of the contractual and fiduciary relationship between the insured and insurer," the second sentence specifically mentioned insureds and claimants, indicating that the legislature intended to create a cause of action for third-party claimants in certain circumstances. The court went on to decide, however, that subsection (B) was an exclusive, rather than an illustrative list and the court included some loose language in the opinion which has been read by several courts to extend to both bad faith claims by insureds as well as bad faith claims by third party claimants. A careful reading of the court's extensive analysis, however, indicates that all of the reasons cited by the court for reading 1220(B) as an exclusive – rather than an illustrative – list apply only to third-party claimants and not to the duties owed by an insurer to its own insured.

The Fifth Circuit faced this issue head-on in *Stanley v. Trinchard*, 500 F.3d 411 (5th Cir. 2007) and decided that the listing in 1220(B) was not an exclusive list of ways in which an insurer could breach its duty of good faith to its insured. In *Stanley*, an insurer settled a civil rights action for policy limits without obtaining a full release for its insured. The insured contended this was bad faith, and also that the insurer committed bad faith by failing to advise it of the extent of its continued liability after the settlement.

Eventually, a bankruptcy ensued and the trustee in bankruptcy was substituted for the insured. The district court granted summary judgment for the insurer reasoning that the allegations of bad faith did not fall within the listed actions enumerated in 1220(B). The Fifth Circuit reversed.

Without quoting *Theriot*, the Fifth Circuit examined the reasoning behind *Theriot* and limited *Theriot's* holding to claims by third-party claimants, stating as follows:

> At the conclusion of its extensive analysis, the *Theriot* court ruled that, even though "a cause of action directly in favor of a third-party claimant against a tort-feasor's insurer is not generally recognized absent statutory creation," La. R.S. 22:1220(B) "create[s] certain limited causes of action in favor of third-party claimants that derogate from established rules of insurance law." The *Theriot* court took pains to make clear that "[i]t is the relationship of the parties that gives rise to the implied covenant of good faith and fair dealing" between the insurer and insured. Inasmuch as *it is not the statute that creates the insured's cause of action against the insurer, the bases for an insured's cause of action for a breach of the implied covenant of good faith and fair dealing are not limited to the prohibited acts listed in La. R.S. 22:1220(B).*

Id. at 427 (emphasis added). The Fifth Circuit found that the district court committed error by holding that an insurer's duty of good faith to its insured is limited to those items listed in 22:1220(B). The court then went on to examine whether any of the allegations made by the insured could constitute a breach of the insurer's duty of good faith to its insured. The Fifth Circuit recognized that the following two actions not listed in the statute could potentially be a breach of the duty of good faith depending upon the facts proved at trial:

- Settling litigation for policy limits without negotiating a full release for the insured; and
- Misrepresentation of policy terms and limits and nondisclosure of essential information about settlement.

Actual damages not required

Another controversy recently resolved by the Louisiana Supreme Court is whether a plaintiff must prove actual damages in order to recover the penalty of subsection (C) of the statute. In *Oubre v. Louisiana Citizens Fair Plan*, *supra*, the court examined the plain language of § 22:1973(C) which provides for a penalty award of "two time the damages sustained or five thousand dollars, whichever is greater." The court hearkened back to its earlier decision in *Sultana Corp. v. Jewelers Mut. Ins. Co.*, 860 So. 2d 1112 (La. 2003), in which it held that an insured is not required to prove that it suffered damages as a prerequisite for a discretionary award of penalties under § 22:1220. Thus, when damages are not proven, as was the case in the *Oubre* class action, the five thousand dollars acts as a ceiling on the penalty award. In *Oubre*, the Supreme Court affirmed the penalty of $5,000 per class member upon simple proof that the insurer failed to initiate loss adjustment within the required time period, resulting in a total award of over $92 million.

Mental anguish damages available

In *Wegener v. Lafayette Ins. Co.*, 2010-0810 (La. 3/15/11), 60 So. 3d 1220, the Louisiana Supreme Court held that mental anguish damages are available under La. R.S. 22:1973 and that they may be awarded regardless of the insurer's intent. The court supported its decision by reference to its prior opinion in *Manuel v. Louisiana Sheriff's Risk Management*, 95–0406 (La. 11/27/95), 664 So. 2d 81. Although *Manuel* did not deal with mental anguish damages, the court in *Manuel* explained that the duties imposed by La. R.S. 22:1973 are separate and distinct from any duties imposed by the contract of insurance. In further support of its decision that damages under La. R.S. 22:1973 do not necessarily follow rules applicable to damages for breach of contract, the court also cited with approval a recent case from the United States Fifth Circuit Court of Appeals interpreting Louisiana law, *Dickerson v. Lexington Ins. Co.*, 556 F.3d 290 (5th Cir. 2009).

Conclusion

Louisiana's law of bad faith has been codified in two statutes. The language of these statutes has been interpreted in case law, and the meaning behind various provisions

has been particularly clarified in the era of post-Katrina litigation. Insurers cannot blindly rely on the old "arbitrary, capricious or without probable cause" standard. That standard does not apply to claims for untimely initiation of loss adjustment, and apparently it will not protect insurers from penalties for errors in policy interpretation. The addition of Louisiana's second penalty statute (now 22:1973) codified the existing law regarding the duty of an insurer to deal with its insured in good faith, but did not supplant it. The statute did, however, extend new causes of actions to third-parties who were strangers to the insurance contract. As recently decided by the Louisiana Supreme Court, penalties under this statute may be awarded even without proof of actual damages, and damages may include mental anguish suffered as the result of an insurer's bad faith conduct.

While Louisiana's law of bad faith does not allow for unlimited punitive damages, there remain many potential traps for the insurer in the statutory language and jurisprudence.

DEVELOPING OR DEFENDING A BAD FAITH CASE: SELECTED PROBLEMS

While there are many aspects to developing and defending a bad faith case, this paper will focus on three potential trouble-spots. First, it will explore issues of retention of defense counsel by an insurer, an area rife with potential for bad faith claims. Second it will explore discovery of insurer claims files in bad faith cases. Third and last, it will explore the use of experts in insurance bad faith cases.

Retaining defense counsel when an insurer reserves rights

It is axiomatic that an insurer's duty to defend is broader than its duty to indemnify. Therefore, even though an insurer may be firmly convinced that, at the end of the day, its policy will offer no coverage for an event, the insurer may still have a duty to defend a suit against its insured. This duty to defend is formulated differently depending upon the law of any particular state, but a common formulation simply requires a comparison of the allegations of the petition with the language of the policy. If under any reasonable reading of the petition any of the allegations would be covered (without reference to actual facts), the insurer most likely has a duty to defend the entire suit.

When an insurer undertakes a defense under these circumstances, the insurer normally writes the insured a reservation of rights letter. The insurer explains the problems with coverage, delineating allegations or outcomes that would not be covered. The insurer then offers to nonetheless defend the case for the insured pursuant to its duty to defend. So far so good.

Many jurisdictions recognize that this situation can create a conflict of interest between the insurer and the insured. Bluntly, if there is no coverage, the insurer will ultimately not pay anything. If there is coverage, the insurer may ultimately have to pay for a settlement or judgment. Because of this undeniable fact, most jurisdictions allow the insured to retain independent counsel whenever the reservations in the case set up a situation where defense counsel could influence the outcome of the coverage issue.

Not all reservations create such a conflict. For example, if the case includes allegations of punitive damages and the policy does not cover punitive damages, a

reservation of rights on this ground normally does not create a conflict. The attorney hired by the insurer to defend the insured has no impetus, conscious or unconscious, to steer the case toward an award of punitive damages against his client. But if, as another example, the reservation addresses allegations of intentional acts, an attorney hired by the insurer in theory could benefit the insurer by steering the case toward a finding of intentional versus negligent conduct. If the insured's actions were intentional, and not simply negligent, the intentional act exclusion would apply and the insurer would have no coverage. (Of course, no ethical attorney would engage in such conduct, but conflicts analysis encompasses possibilities as well as probabilities, subconscious influences as well as admitted ones, and appearances as well as actualities.)

The existence of a conflict created by certain types of reservations of rights will entitle the insured to retain counsel independent of that offered by the insurance company with the insurance company paying the bill to fulfill its duty to defend. States vary as to who picks the attorney and how the attorney is to be paid. Many allow the insured to select the attorney, while others require that the decision be made jointly by both the insurer and the insured. A few states limit the fees of independent counsel to those that the insurer traditionally pays its panel counsel, while others set no such limits, mindful of the ethical obligations of all attorneys to charge only such fees as are reasonable.

The law on this issue is most highly developed in the state of California. The landmark case of *San Diego Federal Credit Union v. Cumis Ins. Society, Inc.*, 208 Cal. Rptr. 494 (Cal. 1984) explained several principles which were later codified in California Civil Code § 2860. Louisiana is a comparative latecomer.

The seminal Louisiana case is *Belanger v. Gabriel Chemicals, Inc.*, 2000-0747 (La. App. 1 Cir. 5/23/01), 787 So. 2d 559, *writ denied*, 2001-2289 (La. 11/16/01), 802 So. 2d 612. There the insured, Gabriel Chemicals, was faced with personal injury lawsuits alleging that the plaintiffs were exposed to harmful emissions from the insured's chlorosulfuric acid plant. The insurer, Lexington, denied coverage and sought summary judgment. Gabriel Chemicals hired its own independent counsel who sought a countervailing summary judgment that Lexington was required to pay his past and future

fees. The trial court denied Lexington's motion and granted Gabriel Chemicals' motion, stating that Gabriel Chemicals had a right to be defended by counsel of its own choosing given that Lexington had denied coverage and created a potential conflict of interest.

The First Circuit, in an opinion written by Judge Kuhn, affirmed. While not completely clear, it appears that Lexington had offered two attorneys of its own selection to Gabriel, and Gabriel had rejected these attorneys and selected its own counsel. The court stated:

> In this case, Gabriel Chemicals' action of hiring independent counsel evinces a lack of consent to the representation of the two attorneys offered to them by Lexington. At a minimum, this record establishes that the representation of either of the two attorneys offered to Gabriel Chemicals by Lexington may constitute a breach of Rule 1.7. Such representation would ostensibly "be materially limited by [each] lawyer's responsibilities to another client or to a third person," i.e., each attorney's responsibilities to Lexington inasmuch as Lexington retains/delegates an attorney for its insured, Gabriel Chemicals, whose primary role at this juncture is addressing insurance coverage. Under the jurisprudence and the rules of the Rules of Professional Conduct, separate counsel must be employed to represent Gabriel Chemicals to avoid a conflict of interest. We find no error in the trial court's conclusion that, under the facts presented, Gabriel Chemicals is entitled to select independent counsel.

Id. at 565.

A second important issue addressed by the court was the hourly rate of the independent counsel hired by Gabriel Chemicals. The insurance policy in *Belanger* had a specific endorsement known as a "Cumis endorsement" which stated that in the event the insurer was required to pay for independent counsel selected by the insured, the fee they would pay would be limited to what they would normally pay to counsel the insurer would retain in the handling of similar claims. The First Circuit found that that endorsement was not ambiguous and was enforceable.

The next case to address the issue in Louisiana was *Smith v. Reliance Ins. Co. of Illinois*, 2001-0888 (La. App. 5 Cir. 1/15/02), 807 So. 2d 1010. This case also involved

an alleged toxic release and suits by multiple plaintiffs for damaged caused by noxious odors. The insurer denied coverage to the defendant on numerous grounds and refused to defend. The defendant third partied the insurer to provide a defense and cross motions for summary judgment were filed.

The Louisiana Fifth Circuit agreed that there was a duty to defend because the policy as a whole did not unambiguously exclude coverage for the allegations of the petition. The insurer argued that it could discharge this duty by appointing an attorney of its own choosing. The Fifth Circuit disagreed with this proposition, citing *Belanger*:

> In the recent decision of *Belanger v. Gabriel Chems, Inc.*, 00-0747 (La. App. 1st Cir. 5/23/01), 787 So. 2d 559, 563 cited by appellee, the court found that when the insurer denies coverage, there is a conflict of interest between the insured and the insurer. Further, the court found that the denial of coverage by the insurer is an event which entitles the insured to select independent counsel to represent them at the insurer's expense. *Id*. at 566. In reaching this conclusion, the court relied on Corpus Juris Secundum, 46 C.J.S. 1157, and held that the insurance company must underwrite the reasonable costs incurred by an insured in defending an action with counsel of its own choosing.
>
> We agree with the reasoning set forth in the *Belanger* case. In the present case, Reliance vigorously albeit unsuccessfully denied coverage in an effort to avoid providing a defense to the Port. The plaintiffs' allegations and Reliance's claim of coverage exclusions create a conflict of interest between the insurer and its insured which entitles the insured to assume control of the defense of the tort action and to select its own counsel. Reliance must underwrite reasonable costs incurred by the insured.

Id. at 1022.

Finally, a case from the U.S. Fifth Circuit retreats a bit from the ground occupied by *Belanger* and *Smith*. In *Trinity Universal Ins. Co. v. Stevens Forestry Service, Inc.*, 335 F.3d 353 (5th Cir. 2003), the Fifth Circuit held that when an insurer had provided defense counsel, to whom the insured had not objected, the insured was not entitled to be reimbursed for the fees of additional counsel independently hired by the insured to

protect its interest due to the insurer's reservation of rights. In a footnote, the U.S. Fifth Circuit distinguished *Belanger* and *Smith*:

> FN3. Stevens points out that two Louisiana intermediate appellate court decisions, issued after National Union, have found that, at least in certain circumstances, an insurer who contests coverage is liable for the attorneys' fees if the insured hires separate counsel. *See Smith v. Reliance Ins. Co.*, 807 So. 2d 1010, 1022 (La. Ct. App. 2002); *Belanger v. Gabriel Chems., Inc.*, 787 So. 2d 559, 565-67 (La. Ct. App. 2001). This, argues Stevens, necessitates the invalidation of National Union. We disagree.
>
> These cases are distinguishable from *National Union* and not on point in this case. Both involved an insured who wished to reject the insurer's proffered counsel and instead employ independent counsel. *See Smith*, 807 So. 2d at 1022; *Belanger*, 787 So. 2d at 565-67. Here, as in *National Union*, the insured accepted insurer's counsel, but also wished to receive reimbursement for independent counsel.

Id. at 356. (The *National Union* case referred to by the court is a 1990 U.S. Fifth Circuit case in which the court held that an insured may recover fees for an attorney hired by the insured, as opposed to the insurer, if the attorney provided by the insurer was objectively inadequate.)

Situations involving independent counsel require close attention and sensitive handling by both the insurer and the insured. They tend to raise mistrust on both sides and, if not appropriately dealt with at the outset of litigation, can spiral into claims of bad faith.

Discovery of claims file

In many bad faith actions, the insured must prove that the insurer was "arbitrary, capricious, or without probable cause." While this is a statutory standard in Louisiana, most jurisdictions likewise require some component of scienter to find that an insurer has acted in bad faith. The contents of a claims file are ideal proof of what the insurer was thinking when it handled the claim. As one court put it:

> [B]ad-faith actions against an insurer, like actions by client against attorney, patient against doctor, can only be proved

> by showing exactly how the company processed the claim, how thoroughly it was considered, and why the company took the action it did. The claims file is a unique, contemporaneously prepared history of the company's handling of the claim; in an action such as this the need for the information in the file is not only substantial, but overwhelming. The "substantial equivalent" of this material cannot be obtained through other means of discovery. The claims file "diary" is not only likely to lead to evidence, but to the very important evidence on the issue of whether [the insurer] acted reasonably.

Brown v. Superior Ct., 670 P.2d 725, 734 (Ariz. 1983).

This view was echoed by Louisiana's First Circuit in *Lehmann v. American Southern Home Ins. Co.*, 615 So. 2d 923 (La. App. 1 Cir. 1993), *writ denied*, 617 So. 2d 913 (La. 1993). There the court agreed that the claims files represented perhaps the only evidence regarding the insurance company's actions in refusing to settle certain claims. The court asserted that the plaintiffs could not obtain the substantial equivalent of this information by deposing claims personnel, because without the claims file those personnel would have to rely on memory rather than contemporaneous record. Accordingly, the court found that the trial court properly ordered the defendant to produce the entire claims file for *in camera* viewing, so that the trial court could examine the file and pull out only those documents that were subject to privilege. *See also Lewis v. Warner*, 94-1643 (La. 7/1/94), 639 So. 2d 1182 and *Wenck v. Standard Fire Ins. Co.*, No. 91-1617, 1992 WL 193540 (E.D. La. Aug. 6, 1992).

Some significant items that may be found in a claims file include:

- claims notes
- bills and estimates
- documentation of investigation
- internal correspondence (typically e-mail)
- correspondence with defense counsel
- correspondence between the insurer and its reinsurers
- reserve and reserve change information

Claims files are also quite likely to contain materials prepared in anticipation of litigation (work product) and attorney-client privileged communications. However, it would be a rare claims file that consisted only of protected information, and, in certain circumstances, the work product doctrine does not offer complete protection and the attorney-client privilege may be waived.

Ibrahim v. Hawkins, 2002-0350 (La. App. 1 Cir. 2/14/03), 845 So. 2d 471, demonstrates the power of the claims file in proving a bad faith case. Ibrahim was injured in an auto accident in February, 1999. He filed suit against the other driver, Hawkins, and Hawkins' insurer, State Farm, in January, 2000. He later amended to add his own UM carrier, Allstate, when it turned out that State Farm's limits were only $25,000.

Ibrahim suffered a broken rib and a right shoulder injury in the accident which eventually required arthroscopic surgery. He missed time from work and underwent physical and psychological therapy. State Farm paid its policy limits and Ibrahim then dismissed Hawkins and State Farm from the case. Allstate tendered its $5,000 med pay limits and eventually tendered another $29,569 in UM payments. The case proceeded to trial against Allstate for additional UM payments, penalties and attorney fees. Following trial the court found that Ibrahim had proved damages considerably in excess of Allstate's UM limits of $50,000 and awarded a judgment that included the following:

- $20,431 (the remaining balance of Allstate's UM limits)
- $40,862 (penalties calculated at twice the remaining limits)
- $26,527 (attorney fees calculated at 1/3 of the net judgment)

Allstate appealed claiming that the trial court erred in finding that it was arbitrary and capricious and thus deserving of penalties. The court noted that the key facts to be considered were what Allstate knew about Ibrahim's injuries, when it became aware of the information, and how it responded.

Allstate's claims file contained a letter from the plaintiff attorney sent two months after suit was filed attaching medical records, medical bills and verification of lost wages. In response, Allstate tendered its med pay limits of $5,000 and told Ibrahim's attorney

that it felt "no UM tender [was] in order." At trial, Allstate's adjuster testified she gave no credence to the loss of consortium claim of Ibrahim's family members and limited lost wages to the 15 weeks Ibrahim's doctor said he could not work at all. She ignored the fact that, as shown in the documentation in her claims file, when Ibrahim went back to work he could only work 20 hours per week due to limitations imposed by his doctor – a fact also verified by his employer. She also ignored the fact that Ibrahim was expected to incur future medical expenses because he was still being treated at the time and his doctor had recommended arthroscopic surgery. Allstate's claims file included a computerized assessment for general damages dated April 21, 2000, which showed nothing for wage loss incurred or expected and nothing for expected medical specials.

In August, 2000, Ibrahim's attorney sent more information to Allstate showing that State Farm had paid its limits and also providing a second medical opinion showing that Ibrahim was in need of arthroscopic surgery. Allstate updated its computerized assessment and tendered an additional $19,608. This figure was reached by considering only the initial lost wages, the surgeon's fee for the anticipated surgery, past medical bills and a figure of $30,000 for general damages, all subject to a credit of State Farm's policy limits of $25,000 plus the $5,000 med pay already paid. The figure did not include anything for the expected anesthesiology or hospitalization costs and no adjustment for lost wages.

After Ibrahim underwent arthroscopic surgery, Ibrahim's attorney sent more information to Allstate including updated medical records and invoices. The attorney again asked for payment of the full UM limits. Allstate tendered $9,961 which was attributable largely to an increased estimate of general damages, but included nothing more for wage loss and nothing for loss or consortium or continuing medical treatment.

Before trial, Ibrahim's attorney sent updated medical bills which now totaled nearly $22,000 and a report from a psychiatrist who had treated Ibrahim for nervousness and depression beginning in March, 2000. Allstate refused to increase its tender.

The appellate court affirmed the trial court's finding that Allstate had been arbitrary and capricious. The claims file showed that, although Allstate was aware of the

need for surgery when it made its first tender, it failed to increase general damages to account for that, failed to include an anesthesiologist fee or a hospitalization fee, and failed to properly account for lost wages. Also, the claims file showed that, according to the psychiatrist's notes, Ibrahim sought treatment for problems stemming from his accident, yet Allstate refused to allow anything for the psychiatrist. The court said:

> [W]e conclude there was evidentiary support for the trial court's findings. Although all payments were made within thirty days from receipt of information, Allstate's estimates conveniently overlooked portions of that information, resulting in unreasonably low payments at each juncture. Moreover, despite receiving additional information regarding psychiatric treatment after its last tender, Allstate made no effort to adjust either its medical specials or general damages to account for Ibrahim's mental problems that were clearly attributable to the accident. Finally, throughout the evaluation process, Allstate totally ignored the claims of Ibrahim's wife and children. Accordingly, we find no manifest error in the trial court's conclusion that Allstate was arbitrary and capricious in its handling of Ibrahim's claim.

Id. at 481.

Ibrahim proved his claim by digging into Allstate's claims file. No other evidence could have so clearly proven what information Allstate had, when it had the information, and what it did with it. (Unfortunately for Ibrahim, the court did reduce the amount of penalties and attorney fees awarded, finding the trial court had incorrectly calculated these amounts.)

Of course, claims files often contain protected information that may not be discoverable such as letters between the insurer and its own attorney containing evaluation and legal advice. In *Dixie Mill Supply Co., Inc. v. Continental Cas. Co.*, 168 F.R.D. 554 (E.D. La. 1996), Magistrate Wilkinson of the Eastern District addressed privileged information contained within a claims file. There, the plaintiff, Dixie Mill, sued its insurers for failure to defend it in numerous asbestos cases. Dixie Mill asserted that its insurers were in bad faith. The insurers logically asserted the defense that they were in good faith. Dixie Mill then argued that its insurers had affirmatively placed at

issue their state of mind and their knowledge of Louisiana law, which must have come from their attorneys, by asserting that they acted in good faith in compliance with the insurance policies and their legal obligations.

Magistrate Wilkinson rejected this argument. Louisiana case law does recognize the concept of "at issue" waiver because of the unfairness that would arise from permitting a client to insist on the privilege when he intends to use privileged information at trial. But Dixie Mills' argument swept too broadly. The insurers asserted that they did not intend to raise an "advice of counsel" argument at trial. The focus in "at issue" waiver is on the defendant's need to use the materials at trial, not on the plaintiff's need for the materials to prove their case of bad faith. In Magistrate Wilkinson's view, the reasonableness of an insurer's actions in a bad faith case can be proven by objective facts, which are not shielded from discovery and do not *necessarily* require the production of privileged materials at trial. Thus Magistrate Wilkinson upheld the attorney-client privilege for certain materials in the claims file, although he did allow discovery of certain communications, noting that letters "which do not contain any confidential communications or attorney advice, opinion or mental impressions, are not privileged simply because they are written by or to an attorney." *Id.* at 559.

In contrast to *Dixie Mill*, in *EPCO Carbondioxide Products, Inc. v. St. Paul Travelers Ins. Co.*, No. 06-1800, 2007 WL 4560363 (W.D. La. Dec. 21, 2007), Magistrate Hayes overrode certain claims of privilege in a bad faith case. In *EPCO* the plaintiff sued Travelers as its property insurer for failure to timely pay, failure to timely investigate, and refusal to pay a claim for accidental damage without a valid defense. EPCO sought production of Travelers' entire claim file. Travelers produced parts of its claims file but asserted privilege and work product protection as to other parts. Magistrate Hayes directed Travelers to provide a privilege log which was to include for each withheld document or entry: the date of the document or entry, the name of its author and recipient, the names of all people given or forwarded copies of the document or entry, the subject of the document or entry, and the specific privilege or privileges asserted.

Once Travelers produced the privilege log, Magistrate Hayes found the log lacking in several respects:

> …Travelers did not adduce evidence to establish that the entries in the claim file were kept confidential. Indeed, some entries suggest that the communications were shared with individuals acting on behalf of other parties. Travelers also did not identify the positions or capacities of the parties mentioned in the documents. The entries refer to staff counsel, but Travelers does not explain counsel's affiliation with the company. If by "staff" counsel Travelers means "in-house" counsel, then the scope of the privilege becomes more difficult to discern because in-house counsel enjoys a higher level of participation in the day to day operations of the corporation. The attorney-client privilege "attaches only to communications made for the purpose of giving or obtaining legal advice, not business or technical advice." While the documents contain some communications by staff counsel that plainly constitute legal advice, other communications with counsel are less discernible without evidence explaining the capacity and extent of staff counsel's employment.

Id. at *2 (citations and references omitted).

Magistrate Hayes went on to explain that work product protects only documents created for the purpose of aiding in future litigation, not documents created in the ordinary course of business. Insurance claims files "straddle" the fence because it is in the ordinary course of business for insurance companies to investigate claims with an eye toward litigation. Travelers failed to establish that the withheld documents were prepared only because litigation was anticipated. Also, Travelers did not show that staff counsel would become involved only in claims where litigation was anticipated. The mere assertion that materials are privileged does not establish that they are. Accordingly, Magistrate Hayes ordered production of the documents.

In sum, claims files contain essential information to proving a bad faith case because they show day by day what information the insurance company had and what the company was doing with the information. However, claims files may also include materials subject to attorney-client privilege or the work product doctrine. Insureds

should seek production of claims files in bad faith cases, and insurers should carefully document any claims of protection in a detailed privilege log. Not all communications between an attorney and an insurance company will be protected – the privilege or protection must be established by the insurer. Insureds should be alert to ways of overcoming privilege and work product, particularly if the insurer asserts an advice of counsel defense.

Use of experts in bad faith litigation

As bad faith lawsuits have become increasingly prevalent, litigants on both sides often seek to introduce expert testimony to support their positions. Courts have reached different conclusions on whether expert testimony is admissible at all, and, if it is, the type of testimony that may be considered and its limits.

In Louisiana, the use of experts in bad faith litigation was first examined in the case of *Marketfare Annunciation, LLC v. United Fire & Casualty Co.*, No. 06-7232, 2008 WL 1924242 (E.D. La. Apr. 23, 2008). There the plaintiff , a grocery store, claimed property damages as a result of Hurricane Katrina. Plaintiff sued its property insurer claiming that the insurer failed to pay the entire amount of the loss due under its policy. The insurer attempted to introduce expert testimony to prove "the obligation of an insurer to determine which part of a claimed loss is covered by flood insurance; the adequacy of instructions given by an insurer to be [*sic*] an adjuster; the rules or codes of acceptable conduct for insurance adjusters; the adequacy of training given to adjusters; and the insurance industry standards for reporting and adjusting insurance claims."

After reviewing cases from other jurisdictions both allowing and excluding expert testimony, Judge Barbier excluded the testimony because the defendant failed to make clear why expert testimony was necessary for the jury to understand the reasonableness standard in La. R.S. 22:658 and 22:1220. Judge Barbier felt that a jury was capable of deciding the case without such testimony by using their common sense and the legal instructions he would give.

In *Imperial Trading Co., Inc. v. Travelers Property Cas. Co. of America*, 654 F. Supp. 2d 518 (E.D. La. 2009), Judge Sarah Vance considered a similar question of the

admissibility of expert testimony. Again, the plaintiffs were commercial businesses who claimed that their property insurer failed to properly adjust their claim following Hurricane Katrina. Plaintiffs sought to introduce the testimony of Peter Knowe. The defendant challenged Knowe's qualifications as an expert and also challenged the substance of his testimony.

Judge Vance found that Knowe was adequately qualified by reason of considerable educational and professional background in the insurance industry, much of which was spent adjusting claims and evaluating complex litigation, including bad-faith litigation. Additionally, Judge Vance noted that he had been previously qualified as an expert in both state and federal courts.

Nonetheless, Judge Vance ruled that Knowe would not be allowed to testify for several different reasons. First, some of Knowe's testimony as outlined in his report had become moot by virtue of the court's rulings eliminating some of the issues in the case. Second, Judge Vance agreed with Judge Barbier that the issue of whether the defendant acted arbitrarily, capriciously, or without probable cause was not unusually complicated and was "well within the comprehension of the average juror." Third, Judge Vance found that although certain aspects of the case were sufficiently technical such that expert testimony would be of some benefit, Knowe's report was simply too conclusory and lacking in methodical analysis to be admitted. She stated:

> The report contains virtually no citations. It provides no basis for many observations and conclusions. The report provides numerous opinions as to the scope of the policy's coverage, but at no point does Mr. Knowe explain his analysis of the policy. In fact, the policy language is not cited in the report at all. Mr. Knowe's report does not explain how numerous, repeated conclusions about defendant's conduct – that it was "dishonest," "deliberate," "arbitrary and capricious," "unreasonable," "unfair," "in bad faith" – were reached. In short, it is difficult to discern any method at work in much of the analysis, and the Court cannot determine how the conclusions stated are the result of Mr. Knowe's expertise. While it is clear that Mr. Knowe has considerable experience in the insurance industry, his process for coming to conclusions is opaque.

Id. at 522. Last, Judge Vance found that Knowe's opinions contained legal conclusions which not only were inadmissible but were also legally incorrect. For all of these reasons, Knowe's testimony was excluded.

Judge Africk took a different view of Knowe in *Huey v. Super Fresh/Sav-A-Center, Inc.*, No. 07-1169. 2009 WL 604914 (E.D. La. Mar. 9, 2009). There, he found Knowe's testimony admissible on industry standards for handling claims involving multiple insureds or additional insureds. Judge Africk viewed these issues as adding a layer of complexity not present in the typical post-Katrina property damage case. However, Judge Africk cautioned that Knowe would be "precluded from testifying to any legal conclusions, including whether Commonwealth's conduct rises to the level of bad faith, whether Commonwealth acted in accordance with its duty of good faith and fair dealing, whether Commonwealth's conduct was intentional, arbitrary and capricious, or malicious, and whether plaintiffs constitute additional insureds under the Commonweath policy." *Id.* at *2.

Judge Berrigan sought to reconcile the views of Judge Barbier and Judge Africk when she decided *200 South Broad Street, Inc. v. Allstate Ins. Co.*, No. 07-9237, 2009 WL 2028349 (E.D. La. July 9, 2009). There the defendant moved to exclude the expert testimony of James Greer. Judge Berrigan found that the facts before her fell somewhere in the "gray area" between the *Marketfare* and *Huey* cases. "On the one hand, this case concerns two separate business policies, which may prove more complex than a typical homeowner case. On the other, this case does not involve multiple payees or claims." *Id.* at *1. Judge Berrigan agreed to allow Greer's testimony but cautioned that she would not permit him to testify to legal conclusions, nor could he give an opinion as to whether the defendant was in bad faith.

Louisiana judges have become very familiar with bad faith litigation in the wake of the 2005 hurricanes and the explosion of insurance litigation that ensued. As these cases illustrate, the courts are only cautiously open to allowing expert testimony about bad faith issues. In run-of-the-mill cases, the courts have not allowed the testimony, instead relying upon the common sense of the jury to determine whether the insurer's

conduct was unreasonable. However, in a complex case, expert testimony has been allowed, with the caveat that experts are not permitted to offer legal conclusions or to opine on ultimate fact issues of bad faith.