1. **Avoiding the bad faith trap.**

LSA-R.S. 22:1973 (formerly 22:1220):

§ 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.

* * *

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.

Notes on bad faith under LSA-R.S. 22:1973

A. No attorney's fees are available under LSA-R.S. 22:1973. Allstate Insurance Company v. Duncan, 96-1603 (La. App. 3rd Cir. 6/18/97), 703 So. 2d 36.

B. Items B-1 through B-4 form the exclusive grounds for a third party bad faith claim under LSA-R.S. 22:1973. B-5 applies only to persons insured under the policy. Theriot v. Midland Risk, 694 So. 2d 184 (La. 1997).

C. B-1: Misrepresenting pertinent facts or policy provisions. Recently, the Louisiana Supreme Court, on certification from the Fifth Circuit Court of Appeals, was asked to address whether this provision applied only to the misrepresentation of policy provisions or whether it was broader in scope. Several lower courts had previously held the misrepresentation must pertain to coverage. The Supreme Court advised an insurer can be held liable under B-1 for misrepresenting or failing to disclose pertinent facts not related to coverage. Kelly v. State Farm, (La. 5/5/15), 169 So.3d 328. This interpretation is concerning as the Court left undefined what constitutes a "pertinent fact." Since Kelly, no other courts have addressed this issue.

As there is no writing requirement, a claimant could say that he talked to an adjuster by phone and the adjuster misrepresented some fact and it becomes a swearing match between the claimant and the adjuster. Recording phone calls should protect you from this risk. Further, you can get some protection from having firm company rules. i.e.: all telephone conversations are to be properly and completely documented in adjuster's log.

D. B-2: Failing to pay the settlement within thirty days. This Section requires that the settlement agreement actually be reduced to writing before the thirty days start to run.

E. B-3: Altered application... This one is self-explanatory.

F. B-4: Misleading a claimant as to an applicable prescriptive period. Again, this one is scary because there is no requirement that the "misleading statement" be in writing.

G. B-5: Failing to pay within sixty days of satisfactory proof of loss. This applies only to "persons insured by the contract." So third parties cannot make a claim under this Section. Theriot v. Midland Risk, 694 So. 2d 184 (La. 1997). The failure must be "arbitrary, capricious, or without probable cause." Whether refusal to pay a claim is arbitrary, capricious, or without probable cause depends upon facts known to the insurer at the time of its refusal to pay the claim. Coco v. State Farm Mutual Insurance Company, 00-676 (La. App. 3rd Cir. 12/6/00), 775 So. 2d 1131. An insurer's actions are "arbitrary and capricious" for purposes of statute when its willful refusal of a claim is not based on good-faith events or is unreasonable or without probable cause. Wallace v. State Farm, 36099 (La. App. 2nd Cir. 6/14/02), 821 So.2d 704.

H. The claimant is not required to prove that he was damaged by the breach of duty in order to recover the penalty. Sultana Corp. v. Jewelers Mutual Insurance Company, 860 So. 2d 1112, 2003-0360 (La. 12/03/03). If there is no proof of damage caused by the

breach, then the penalty can be less than $5,000 but it cannot exceed $5,000. Obre v Louisiana Citizens Fair Plan, 79 So. 3rd 987, 2011-0097 (La. 12/16/11).

I. Perhaps the most significant implication of the Kelly case discussed above was the additional question posited by the Fifth Circuit and answered by the Supreme Court: specifically, whether an insurer could be found liable for bad faith damages even where there was no firm offer to settle from the plaintiff? The Supreme Court held that a firm settlement offer is unnecessary for an insured to sustain a cause of action against an insurer for a bad-faith failure to settle a claim. In other words, and though this was hardly a new or novel concept, the Kelly Court specifically tied a failure to proactively seek a settlement to penalties under LSA-R.S. 22:1973. However, the extent to which this ruling expands the law is yet to be determined. In addressing the supposed failure of State Farm to adequately protect its insured from an excess judgment, the Supreme Court acknowledged that courts recognized that "tight reigns must be kept on a cause of action for insurer settlement practices. . . . [T]he statute does not contemplate gamesmanship, such as having "unrealistic offers presented through "carefully ambiguous demands coupled with sudden-death timetables' " in order to "set up" the insurer for an excess liability judgment."

LSA-R.S. 22:1892 (formerly 22:658):

§ 1892. Payment and adjustment of claims, policies other than life and health and accident; personal vehicle damage claims; penalties; arson-related claims suspension

A. (1) All insurers issuing any type on contract,..., shall pay the amount of any claim due any insured within thirty days after receipt of satisfactory proofs of loss from the insured or any party in interest.

(2) All insurers issuing any type of contract,..., 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 LSA-R.S. 22:1973.

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

B. (1) Failure to make such payment within thirty days after receipt of such satisfactory written proofs and demand therefore or failure to make a written offer to settle any property damage claim, including a third-party claim, within thirty days after receipt of satisfactory proofs of loss of that claim, as provided in Paragraphs (A)(1) and (4), respectively, or failure to make such payment within thirty days after written agreement or settlement as provided in Paragraph (A)(2), when such failure is found to be arbitrary, capricious, or without probable cause, shall subject the insurer to a penalty, in addition to the amount of the loss, of 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. 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.

* * *

(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 therefore, 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.

Notes on bad faith under 22:1892

A. A-1: Payment within thirty days after satisfactory proof of loss. Applies only to claims "due any insured" thus it does not apply to third party claims, except those "third parties" who may fall under your med pay or UM coverage. The typical claim is for UM benefits requiring a McDill tender.

B. In McDill v. Utica Mutual Insurance Company, 475 So.2d 1085 (La. 1985), the Supreme Court outlined the jurisprudence on "satisfactory proof of loss" which is interpreted as the insurer being made aware (1) that the owner or operator of the other vehicle involved in the accident was uninsured or underinsured; (2) that he was at fault; (3) that such fault gave rise to damages; and (4) the extent of those damages. The Court went on to state that where the first three elements of plaintiff's burden are met and the insured has made a showing that the insurer will be liable for some general damages, the insurer then has the responsibility of unconditionally tendering a reasonable amount which is due. The amount due would be "a figure over which reasonable minds could not differ."

C. An unconditional tender means just that – unconditional. The check should not have any release language on it and you cannot require execution of a release to accept the tender. For example, the insurer's payment by check containing the phrase "final settlement of claim under collision coverage arising from accident" was conditional tender which did not satisfy insurer's obligation to pay insured's claim within thirty days of satisfactory proof of loss, thus subjecting insurer to penalties and attorney's fees. Steadman v. Sotelo, 02-902 (La. App. 5th Cir. 1/15/02), 807 So.2d 911.

D. Reasonableness of insurer's tender of payment and insurer's liability for bad faith are not gauged by simply comparing tender of payment with reserves, but are determined by consideration of facts known to insurer prior to trial and by consideration of question whether reasonable minds can differ on amount that is due in light of those facts. Molony v. USAA Property and Casualty Insurance Company, 97-1836 (La. App. 4th Cir. 3/4/98), 708 So.2d 1220.

E. Remember that when looking at the underlying liability coverage, an underinsured motorist carrier needs information on both the owner and the operator if they are not the same person. However, when the insured presents *prima facie* evidence that the negligent owner/driver has no liability coverage or that the coverage is inadequate, the burden shifts to the UM carrier to show there is other applicable coverage. Gillmer v. Parish Sterling Stuckey, 09-0901 (La. App. 1st Cir. 12/23/09), 30 So.3d 782. Put differently, if the insured has provided you with proof that the owner/operator or owner and operator were uninsured or underinsured, you cannot require them to disprove the possibility of other coverage.

F. Remember to also look for other UM coverage if your insured is making a claim for damages received while riding in a non-owned vehicle. UM coverage on that vehicle would prime the personal coverage of your insured.

G. Remember that in the situation where your insured is injured while riding with an at fault employer or co-employee while in the course and scope of employment, because that person is immune from liability claimed by your insured, they cannot be an

uninsured motorist for purposes of your coverage. Hebert v Clarendon American Insurance Co. 984 2d 952 (La. App 3 Cir. 2008)

H. A-2: Must pay amount of third party property damage and medical expense claim within thirty days of a written settlement agreement. This one is self-explanatory.

I. A-3: Must initiate loss adjustment within fourteen days after notification of loss by the claimant.

1. Notice that the notification must be from the claimant.

2. In initiating loss adjustment, the insurer must take some substantive and affirmative steps in order to accumulate the facts that are necessary to evaluate the claim. However, simply opening a file is not enough. In Rogers v. Commercial Union Ins. Co., 01-0443 (La. App. 3rd Cir., 10/03/01), 796 So.2d 862, the Third Circuit held that the provision was violated where an insurer (1) immediately determined that the claimant was not entitled to damages, (2) explained the "no pay, no play" statute to her, (3) denied her claim because of the statute five days after her initial contact, and (4) did not obtain a copy of the police report or any other investigative steps. The court held that the insurer "spent more time trying to defeat the claim instead of trying to investigate."

3. However, it is not required that the claim be completely resolved or paid within the time period. Thus, penalties are not proper where the insurer, within fourteen days of receipt of notice, took "substantial and affirmative steps to accumulate facts necessary to evaluate the claim." Chatoney v. Safeway, 00-1189 (La. App. 3rd Cir. 06/13/01), 801 So.2d 448; writ denied, 2001-C-2057 (La. 11/2/01), 800 So.2d 875.

J. A-4: Must make a written offer to settle any property damage claim within thirty days after receipt of satisfactory proofs of loss. Notice once again the question is whether you have received satisfactory proof of loss. Even if your offer is "zero", do it in writing.

2. Confidentiality and the secondary release of documents in a claim file.

A. When the request for claim file information comes from law enforcement or the NICB, LSA-R.S. 22:1247 provides broad immunity for insurers for the sharing "without malice, fraudulent intent, or bad faith," of "information . . . concerning suspected, anticipated, or completed fraudulent insurance acts" with "a person involved in the prevention and detection of fraudulent insurance acts." What kinds of "information" you can share is unknown as there are no cases interpreting this statute.

B. When the request for claim file information comes from another insurer or their counsel, be careful with what you release. We recommend that you refuse to release actual medical records in your possession short of a subpoena.

C. The Supreme Court addressed this issue and the key factor in determining that there was no liability for the insurer who released medical records on a prior claim was the fact that the records were produced in response to a subpoena. "Applying these precepts to the case at bar, we find the uncontested facts establish Safeway did not act unreasonably in releasing Mr. Alessi's medical records and bills in response to Barriere's subpoena. The documents at issue were voluntarily submitted by Mr. Alessi to Safeway, without any restrictions on their use. Safeway had no fiduciary relationship with Mr. Alessi to obligate it to protect his records, nor is Safeway an entity covered under the state or federal laws relating to privacy of medical records. Most importantly, Safeway did not produce the records in bad faith; rather, it did so pursuant to a subpoena validly issued by the district court." Alessi v. Loehn, 2011-1914 (La. 12/16/11), 76 So. 3d 1142, 1143

D. So, this is why you should always insist on a valid subpoena before releasing medical records in a claim file.

E. A request for records from a Worker's Compensation Judge follows a little different procedure. Specifically, Under LSA-R.S. 23:1310(C), "Workers' compensation judges shall have the authority to issue subpoenas and subpoenas duces tecum as provided in Louisiana Code of Civil Procedure Articles 1351 through 1354. Subpoenas issued pursuant to this Section may be served by certified mail, return receipt requested." So, a subpoena is still required, but that subpoena can be served by certified mail rather than by the sheriff.

3. Co-employee claims.

A. Worker's Compensation is the sole remedy that co-employees have against each other or their employer when acting in the course and scope of employment. For example, if your insured is driving a co-employee on a mission for their employer when your insured runs a red light and causes an accident that injures the co-employee, that co-employee has no tort claim against your insured or the insurer.

B. The Supreme Court has held that where an employee is engaged in a special mission for employer and is injured en route from employee's home to location of mission or from location to home, he is within the scope of employment from "portal-to-portal." McLin v. Industrial, 02-C-1539 (La. 7/2/03), 851 So.2d 1135.

C. In Posey v. NOMAC Drilling Corp., 44,428 (La. App. 2 Cir. 8/12/09), 16 So. 3d 1211, the court outlined the rules related to transportation to and from work. Generally, injuries sustained by a claimant while traveling to and from work are not considered to have occurred within the course of employment. The going-and-coming rule, which precludes recovery of workers' compensation benefits based on an accident sustained while the claimant is going to or coming from work, is subject to the following exceptions:

(1) if the accident occurred on the employer's premises;

(2) if the claimant was deemed to be on a specific mission for the employer;

(3) if the employer had interested himself in the transportation of the claimant as an incident to employment agreement either by contractually providing transportation or reimbursing claimant for expenses;

(4) if the claimant was doing work for his employer such that consent could be fairly implied;

(5) if the claimant was injured while traveling from one work site to another;

(6) if the claimant was injured in an area immediately adjacent to place of employment and that area contained a distinct travel risk; or

(7) if the operation of a motor vehicle was the performance of one of the duties of employment.

D. What this means: If the claimant was an employee, employer, or co-employee of the insured and the accident happened while in the course and scope of employment, then the claimant has no cause of action in tort against the at-fault employee, employer or co-employee. Since there is no tort claim against the at-fault party, there is no obligation to pay under the liability coverage of the at-fault party or the UM coverage of the injured party.

4. Rental Vehicles.

A. Under Louisiana law, the owner of a rental vehicle is required to maintain security on all rental vehicles, but that coverage is only available as a last resort, to the extent there is no other valid and collectable insurance. LSA-R.S. 22:1296.

B. Thus, if a person rents a motor vehicle his personal liability coverage is primary (this includes comprehensive and collision). However, if a lessee purchases any coverage provided by the rental company, that insurance is primary. Adjusters should get the rental agreement immediately.

C. Permissive Use: LSA-R. S. 22:1296(B)(2) states that:

"Notwithstanding a rental company's obligation to provide minimum financial responsibility pursuant to the Motor Vehicle Safety Responsibility Law as the owner of the vehicle for the privilege of registering and titling such vehicle, a rental company shall be relieved of any security obligation under the Motor Vehicle Safety Responsibility Law when the renter or driver has valid and collectible insurance, self-insurance, bond, deposit, or other form of security in an amount sufficient to satisfy the minimum financial responsibility requirements of the Motor Vehicle Safety Responsibility Law, when the claimant maintains uninsured or underinsured motorist coverage for bodily injury or property damage claims, or when the renter violates the terms or conditions of the rental agreement."

D. If the renter violates the terms of the rental agreement by allowing an unlisted driver to operate the vehicle, then the insurance ordinarily provided by the rental company is not applicable.

E. Does an automobile rental company have to provide UM coverage if it provides liability insurance? No. LSA–R.S. 22:1296 exempts rental companies from UM requirements.

F. Rental vehicles, nonpermisive use, and the driver/renter's insurance: Remember that the rental company, not the renter, owns the rental vehicle. Liability policies only cover drivers using the vehicle with the owner's permission. Rental contracts always require that drivers be listed and that unlisted drivers are not permitted to operate the vehicle. (Not against public policy per Hearty v. Harris, 574 So.2d 1234 (La. 1991)). So, suppose A rents a vehicle and is the only listed driver on the rental agreement. A's liability policy would provide coverage while A is driving. But what if A allows a non-listed operator, B, to drive the rental vehicle? The courts have held that A's (the renter's) insurance still applies. See, Budget Rent-A-Car Systems, Inc. v Allstate Ins. Co., 97-984 (La. App. 5th Cir. 02/25/98), 707 So.2d 1353). However, the non-listed operator's personal liability insurance would not provide coverage because of non-permissive use. Simms v. Butler, 97-0416 (La. 12/02/97), 702 So.2d 686. Thus, if in the above scenario, you insure B, do not assume you have coverage as in all likelihood there exists a valid coverage defense.

G. Note also, however, that if the driver's policy has "reasonable belief" standard of permissive use then that coverage might extend to a rental vehicle even if the driver is unlisted in the rental agreement. Armstrong v. Thrifty Car Rental, 2005-1461 (La. App. 3 Cir. 6/7/06), 933 So. 2d 235

H. Policy ranking issues for rental cars are covered by LSA-R.S.22:1296(A), which provides:

"Every approved insurance company, reciprocal or exchange, writing automobile liability, physical damage, or collision insurance, shall extend to temporary substitute motor vehicles as defined in the applicable insurance policy and rental motor vehicles any and all such insurance coverage in effect in the original policy or policies. Where an insured has coverage on a single or multiple vehicles, at least one of which has comprehensive and collision or liability insurance coverage, those coverages shall apply to the temporary substitute motor vehicle, as defined in the applicable insurance policy, or rental motor vehicle. Such insurance shall be primary. However, if other automobile insurance coverage or financial responsibility protection is purchased by the insured for the temporary substitute or rental motor vehicle, that coverage shall become primary. The coverage purchased by the insured shall not be considered a collateral source."

Summarizing this provision, every insurance company shall extend to rental private passenger automobiles any and all such insurance coverage in effect in the original policy. Where the insured has coverage on multiple vehicles, at least one of which has comprehensive and collision, that comprehensive and collision insurance shall extend to rental vehicles. However, if other insurance coverage is purchased by the insured for the rental vehicle, that insurance shall be primary.

5. Direct Action Statute.

A. LSA-R.S. 22:1269 allows the injured party to sue the insurer directly.

B. The insurer can be named as a party defendant in all third party actions with the only limitation being that the plaintiff must also sue the insured. The only circumstances under which the action may be brought against the insurer alone are when the insured has been adjudged a bankrupt, when the insured has filed bankruptcy proceedings, when the insured is insolvent, when service of citation or other process cannot be made on the insured, the cause of action is a result of a tort between children and their parents or between married persons, when the insurer is an uninsured motorist carrier, or when the insured is deceased. LSA-R.S. 22:1269(B)(1).

6. Healthcare Liens.

A. Pursuant to LSA-R.S. 9:4751, et seq., a healthcare provider has an enforceable lien which is perfected by sending written notice to the injured person, to his attorney, or to the person alleged to be liable to the injured person on account of the injury sustained, or to any insurance carrier which has insured such person against liability. This written notice must include the name and address of the injured person, the name and location of the interested healthcare provider, and the name of the person alleged to be liable to the insured person on account of the injuries received. This privilege is effective against all persons given notice.

B. The notice requirements are set forth in LSA-R.S. 9:4753 as follows:

"A. The privilege created by R.S. 9:4752 shall become effective if, prior to the payment of insurance proceeds, or to the payment of any judgment, settlement, or compromise on account of injuries, a written notice containing the name and address of the injured person and the name and location of the interested health care provider, hospital, or ambulance service is delivered by certified mail, return receipt requested, or by facsimile transmission with proof of receipt of transmission by the interested health care provider, hospital, or ambulance services, or the attorney or agent for the interested health care provider, hospital, or ambulance service, to the injured person, to his attorney, to the person alleged to be liable to the injured person on account of the injuries sustained, to any insurance carrier which has insured such person against liability, and to any insurance company obligated by contract to pay indemnity or compensation to the injured person. This privilege shall be effective against all persons given notice according to the provisions of this Section and shall not be defeated nor rendered ineffective as against any person that has been given the required notice because of failure to give the notice to all those persons named in this Subsection.

B. If delivery of the notice required by this Section is made by facsimile transmission, and the sender fails to obtain a signed proof or receipt within seven days, then delivery shall be made by certified mail, return receipt requested, and costs of mailing shall be taxed as court costs."

C. Pursuant to the provisions of LSA-R.S. 9:4754, any person who, having received such notice, pays over money subject to the lien, remains liable to the healthcare provider for the amount of such lien or privilege, not to exceed the net amount paid to the injured person or his attorney. In other words, if you ignore the lien and pay the claimant or his attorney, then you still owe the amount of the lien, up to the amount of payment made to the claimant or his attorney.

7. Minors – are you dealing with the right person?

A. Who is eligible to bring a suit on behalf of a minor?

When both parents are alive and are not divorced or judicially separated, the father would bring such a suit. LSA-C.C.P. art. 4501. If the parents are divorced or legally separated, then the tutor of the child must bring the suit. If the child is illegitimate, then the mother is the natural tutor and would be the proper party to bring the suit. (This is true in most circumstances).

LSA-C.C. art. 250. Persons entitled to tutorship

Upon the death of either parent, the tutorship of minor children belongs of right to the other. Upon divorce or judicial separation from bed and board of parents, the tutorship of each minor child belongs of right to the parent under whose care he or she has been entrusted; however, if the parents are awarded joint custody of a minor child, then the co-tutorship of the minor child shall belong to both parents, with equal authority, privileges, and responsibilities, unless modified by order of the court or by an agreement of the parents, approved by the court awarding joint custody. In the event of the death of a parent to whom joint custody had been awarded, the tutorship of the minor children of the deceased belongs of right to surviving parent.

LSA-C.C. art. 256. Illegitimate children

A. The mother is of right the tutrix of her illegitimate child not acknowledged by the father, of acknowledged by him alone without her concurrence.

B. After the death of the mother, if the father had not acknowledged the child prior to the mother's death, the court shall give first consideration to appointment as tutor either of her parents or siblings who survive her and accept the appointment, and secondly, the father, always taking into consideration the best interests of the child.

C. If both parents have acknowledged their illegitimate child, the judge shall appoint as tutor the one by whose care the best interests of the child will be served. However, if the parents are awarded joint custody of such acknowledged illegitimate child, then the cotutorship of such child shall belong of right to both parents, with equal authority, privileges, and responsibilities, unless modified by order of the court or by an agreement of the parents, approved by the court awarding joint custody.

B. Is Court approval required for minor settlements?

Not required in cases where the minor receives $10,000 or less after all expenses, costs, and attorney's fees. Otherwise, court approval is mandatory.

LSA-R.S. 9:196 provides:

A tutor who is entitled to tutorship by nature... and without qualifying, may perform or discharge any act affecting the right or interest of the minor which involves not more than ten thousand dollars actually received by the minor, notwithstanding court costs, attorney's fees, and other expenses.

Thus, where the minor nets $10,000 or less, there is no requirement that you qualify the tutor or obtain court approval. You should, however, insure that you are dealing with the proper person. The Civil Code identifies the natural tutor as set forth above.

C. Court of jurisdiction?

The district court in the parish where the minor is domiciled is the proper place to bring a tutorship and/or minor settlement.

8. Priority of claims/multiple claims.

A. Is there a legal priority of payments in multiple claims situations? In other words, should claims be paid on "first come/first served" basis until limits are exhausted or on a "pro rata basis?"

B. In third-party liability cases, the law on this issue is specifically addressed by the Supreme Court in Holtzclaw v. Falco, Inc., 355 So.2d 1279 (La. 1977). In that case, the court held that there is no "pro rata" ownership of insurance proceeds. Instead, an insurer is simply required to act in good faith and use its policy limits to the best benefit of the insured. Basically, you want to try to make the best settlements possible for your insured whereby you use your policy limits to get the insured released from as much excess exposure as possible. The keys are to be reasonable, obtain good deals for releases, and keep your insured informed.

C. Note: in our opinion, depositing money in the registry of the court is rarely a good idea on third-party liability claims because it does not get a release for your insured, and, in fact, forfeits your leverage for negotiating settlements.

D. UM claims must be handled a little differently. Basically, since all claimants are your insureds under the policy you owe duties to each with respect to dividing the money. Therefore, if the limits will clearly be exhausted by the payment of three or more claims (on a split-limit policy) then if the parties cannot agree upon a division between them then you may have no choice but to use the concursus (interpleader) procedure and deposit the money into the registry of the court.

9. Reservation of Rights letter, Non-Waiver agreement, and the protection of coverage defenses.

A. The conduct of the insurer can result in the waiver of coverage defenses. In Tate v. Charles Aguillard Ins. & Real Estate, Inc., 508 So. 2d 1371 (La. 1987), the Louisiana Supreme Court provided a succinct summary of the principle of waiver and estoppel, as it applies to coverage issues, as follows:

"Consequently, we conclude that the best view is that waiver may apply to any provision of an insurance contract under which the insurer knowingly and voluntarily elects to relinquish his right, power or privilege to avoid liability, even though the effect may bring within coverage risks originally excluded or not covered. Of course, reliable proof of such a knowing and voluntary waiver is necessary and the burden of producing it, as in the proof of obligations generally, falls on the party who demands performance."

B. Generally, if an insurer pays all or part of a claim with knowledge of facts that would support the coverage defense then the defense would be waived.

C. There are two different types of mechanisms for reserving coverage defenses while investigating a loss. A "Reservation of Rights Letter" is generally used pre-litigation while a "Non-Waiver Agreement" is contemplated for use post-litigation, where common counsel is employed.

D. A reservation of rights letter should be sent during loss adjustment immediately upon the insurer becoming aware of a coverage issue or when coverage is uncertain. Thus, it is important that reservation of rights letters be sent as soon as the issue arises.

E. If the insurer uses common counsel to defend both the insurer and the insured, a Reservation of Rights Letter is not adequate as the court requires what appears to be a bilateral agreement between the insurer and insured that the court refers to as a "Non-Waiver Agreement". As noted in the decision by the Supreme Court in Steptore v. Masco Construction Co., Inc., 643 So.2d 1213 (La. 1994), when an insurer, with knowledge of facts indicating non-coverage under insurance policy, assumes or continues insured's defense without obtaining non-waiver agreement to reserve its coverage defense, insurer waives such policy defense. In other words, if the same counsel is retained to defend both the insurer and the insured then, unless there is a "non-waiver agreement," the defense will be waived.

In Arceneaux v. Amstar Corp., 10-2329 (La. 7/1/11), 66 So. 3d 438, the Supreme Court outlined the current principles applicable to the reservation of rights and/or a non-waiver agreement:

When insurer, with knowledge of facts indicating non-coverage under insurance policy, assumes or continues insured's defense without obtaining non-waiver agreement to reserve its coverage defense, insurer waives such policy defense.

Waiver may apply to any provision of an insurance contract under which the insurer knowingly and voluntarily elects to relinquish his right, power or privilege to avoid liability, even though the effect may bring within coverage risks originally excluded or not covered.

Waiver principles are applied stringently to uphold the prohibition against conflicts of interest between the insurer and the insured which could potentially affect legal representation in order to reinforce the role of the lawyer as the loyal advocate of the client's interest.

The insurer cannot later avoid liability based on a coverage defense if it has assumed the defense without a reservation of rights and with knowledge of facts which would bring the claim outside the policy based on that defense; a belated disclaimer may prejudice the insured because it loses the opportunity to assume and manage its own defense.

F. Quite frankly, in my opinion, any discussion of using a "Non-Waiver Agreement" to support use of common counsel for insurer and insured in cases involving a coverage issue is academic because most attorneys would never consider such an arrangement. In fact, as I read these cases, the Supreme Court is essentially saying "here is how you do it but don't bother." As contemplated by the court, a non-waiver agreement seems to be more than just a unilateral notice by the insurer which is, of course, the normal format of a Reservation of Rights Letter. A reservation of rights is an ex parte action by the insurer reserving its rights, but the "non-waiver agreement" contemplated by the Supreme Court is a bilateral agreement executed by both parties.

G. Obviously, best practice dictates that once litigation has commenced, if there is a known coverage issue, separate counsel should be provided rather than relying upon a reservation of rights letter or a "non-waiver agreement."

H. In addition to the actions of the insurer necessary to protect coverage defenses, there is a step that your counsel should be taking to ensure that the decision-making authority of the insurer is preserved. Specifically, in a case involving an insured who complained about a case being settled without his consent, the Louisiana Supreme Court imposed the following obligations upon counsel:

"Consistent with this guidance, we interpret Rule 1.2 as requiring a lawyer who represents an insurer and insured in a case involving a "consent to settle" clause to advise the insured as soon as practicable (generally at the inception of representation) of the limited nature of the representation the attorney will provide to the insured. Once the lawyer has made appropriate disclosure to the insured of the limited nature of

the representation being offered under the insurance contract and the insured indicates consent by accepting the defense, the lawyer may then proceed with the representation at the direction of the insurer in accordance with the terms of the insurance contract, including settling the claim within the limits of the policy at the insurer's sole direction." In re Zuber, 2012-0916 (La. 10/16/12), 101 So. 3d 29, 34–35

I. Your attorneys are likely already following this guidance but, if not, here is the language we include in our initial communication with the insured:

"Our firm has been retained by XYZ Insurance Company, who is responsible for payment of our fees. Your insurance contract with XYZ Insurance Company allows it to control the management and progress of the litigation, and to direct how the litigation is defended. That contract also allows XYZ Insurance Company to enter into settlement agreements without your permission or prior consent. Further, your insurance company's duty to settle or defend claims or lawsuits against you ends when the limits of liability under the insurance policy have been exhausted by payment of one or more judgments and/or one or more settlements. Although we will provide the defense of this claim under this policy, you have the right to obtain separate counsel, at your sole and exclusive expense, should you choose to do so."

10. Dismissal and the compulsory Reconventional Demand trap.

A. If the plaintiff's attorney is drafting the dismissal you should look at it carefully.

B. It should always include your insured/ insured driver and be with prejudice because that protects your insured from any re-filing of the same claim.

C. CAUTION: In Louisiana we have compulsory reconventional demands (counter-suit). That means that if your insured is sued, he must bring his own claim by reconventional demand or he will lose the right to bring his claim when you settle. Therefore, when you are dealing with a disputed liability case and you suspect that your insured has his own claim or is represented by counsel, make sure you notify them of suit and remind them that their claims must be brought by reconventional demand.

11. Collateral Source Rule and Healthcare Provider Write-downs:

A. Under the collateral source rule, a tortfeasor may not benefit, and an injured plaintiff's tort recovery may not be reduced, because of monies received by the plaintiff from sources independent of the tortfeasor's procuration or contribution. However, the collateral source rule does not apply if the plaintiff does not pay an enrollment fee, does not have any wages deducted in exchange for the benefit, and does not otherwise provide any consideration for the collateral source benefits he receives.

B. Thus, the plaintiff may not recover his medical expenses which are "written off" by the healthcare provider through Medicaid. Bozeman v. State, 03-C-1016 (LA. 7/2/04), 879 So.2d 692.

C. In those instances where the plaintiff's patrimony has been diminished (such as Medicare or private insurance), plaintiff may recover the full value of the medical services, including the write-off. Bozeman v. State, 03-C-1016 (LA. 7/2/04), 879 So.2d 692.

D. So, to be clear: If the bills are paid by Medicaid you only owe the Medicaid reimbursement to the government and do not have to pay the plaintiff any amounts that may have been written down by the health care provider in compliance with Medicaid. On the other hand, if the medical expenses are paid by Medicare, you have to reimburse the government the amount of its payment and the plaintiff can collect the health care provider write-downs as part of his tort claim.

E. In LeBlanc v. Acadian Ambulance, 99-271 (La. App. 3rd Cir. 10/13/99), 746 So.2d 665, the court stated that a contractual reduction (a PPO discount) is a collateral source because the plaintiff obtains it through his own insurer. Therefore, defendant must pay the full cost without the benefit of such collateral sources.

F. Furthermore, where the plaintiff pays a premium for her health insurance, and her health insurer obtains contractual write-offs from health care providers, evidence of such write-offs should not be presented to a jury determining the plaintiff's award for medical expenses against a third-party tort-feasor. Griffin v. La. Sheriff's Auto Risk Ass'n, 1999-2944 (La. App. 1st Cir. 06/22/01), 802 So.2d 691.

G. Finally, the collateral source rule does not apply to attorney-negotiated write-offs or discounts for medical expenses obtained as a product of the litigation process. In Hoffman v. 21st Century, 14-2279 (La. 10/2/15) ___ So.3d ___, an injured motorist was entitled to reimbursement of only the actual amount paid to and accepted by medical provider for MRI scans, rather than the initial charged amount, which was then discounted pursuant to an arrangement that claimant's attorney had with provider. The Court further implied there were serious ethical implications for an attorney to represent that the bill was more than what was actually paid.

H. Hoffman has been distinguished by the Fifth Circuit in a case where the plaintiff herself negotiated a reduction of her hospital bill independent of some agreement between the provider and the attorney. Lockett v. UV Insurance, 15-CA-166 (La.App. 5th Cir. 11/19/15) 180 So.3d 557.