Collateral Source and New Decisions on Insurance

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Update on the Collateral Source Rule
And New Decisions on Insurance

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I. Introduction

Among a plaintiff lawyer's duties to his client is maximizing the client's net recovery under the applicable law. Two means of doing so are the use of the collateral source rule and the assertion of bad-faith claims against an insurer when appropriate. First, 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. Second, an insurer owes to its insured a duty of good faith and fair dealing. That duty was established by case law and later codified by La. Rev. Stat § 22:1973. And that duty can lead to damages and penalties if breached.

This paper discusses the collateral source rule and claims of bad-faith against an insurer. In particular, we focus on two decisions by the Louisiana Supreme Court: *Bozeman v. State*, 2003-1016 (La. 7/2/04); 879 So. 2d 692, which dealt with the collateral source rule and Medicaid "write-offs," and *Kelly v. State Farm Fire & Casualty Co*., 2014-1921 (La. 5/5/15); 169 So. 3d 328, which involved two questions about an insurer's liability under La. Rev. Stat. § 22:1973. Both cases are critical to understanding these two issues.

The first section of this paper deals with the collateral source rule. After touching on the beginning of the rule, we turn to *Bozeman*. We provide an overview of the facts and procedural background of *Bozeman* and then discuss the Louisiana Supreme Court's analysis. Next, we lay out the different ways the rule has been applied in Louisiana case law. After that, we depart from damages and look at the evidentiary aspects of the rule. Then, we look at *Bozeman*'s

[1] Special thanks is given to Judge deGravelles' law clerk, David Borghardt, who helped us prepare this paper.

discussion about the rule's underlying policies. This in turn leads to an examination of how the Louisiana Supreme Court has addressed the collateral source rule after *Bozeman*; we start with *Bellard v. American Central Insurance Co*., 2007-1335 (La. 4/18/08); 980 So. 2d 654, which provides essential guidance in interpreting *Bozeman*, and conclude with the recent case of *Hoffman v. 21st Century North America Insurance Co*., 2014-2279 (La. 10/2/15); --- So. 3d ----; 2015 WL 5776131, which involved medical expenses "written off" for an attorney's negotiated discount. Lastly, we survey recent developments in Louisiana appellate courts.

The next major section of this paper deals with an insurer's liability for bad faith. We begin with general principles of good faith and liability laid out in *Smith v. Audubon Insurance Co*., 95-2057 (La. 9/5/96); 679 So. 2d 372. Next, we delve into the *Kelly* case; we start with an overview of the decision, proceed into its facts and procedural background, and then discuss each of the two questions analyzed by the Louisiana Supreme Court: (1) can an insurer be liable for a bad-faith failure to settle claim under La. Rev. Stat. § 22:1973(A) when the insurer never received a firm settlement offer? and (2) can an insurer be liable under La. Rev. Stat. § 22:1973(B) for misrepresenting or failing to disclose facts that are not related to the insurance policy's coverage? After a brief look at recent developments, we conclude with a hypothetical that draws together good faith principles: Can an insurer be liable for bad faith if it settles a claim that may lack merit?

II. Collateral Source Rule

A. The Beginning

"The origins of the collateral source rule can be traced to a decision by the United States Supreme Court in 1854, *The Propeller Monticello v. Mollison,* 58 U.S. (17 How.) 152, 15 L. Ed. 68 (1854)." *Bozeman*, 879 So. 2d at 700. The Monticello, a steam-propelled vessel, collided on

Lake Huron with the schooner Northwestern. *The Propeller Monticello*, 58 U.S. (17 How.) at 153. The schooner and its cargo sank, and both were insured. *Id.* at 153—4. The schooner's insurer paid for the losses sustained, including its cargo. *Id.*

The owner of the schooner then filed suit against the owner of the Monticello to recover the value of its cargo. The defendant argued that the owner of the schooner had "received satisfaction from the insurers" and was thus not entitled to recover. *Id.* at 154—55.

The Supreme Court disagreed, and, in doing so, created the collateral source rule. *See Bozeman*, 879 So. 2d at 700. The Supreme Court explained, "[t]he contract with the insurer is in the nature of a wager between third parties, with which the trespasser has no concern. The insurer does not stand in the relation of a joint trespasser, so that satisfaction accepted from him shall be a release of others." *The Propeller Monticello,* 58 U.S. (17 How.) at 155. The Court held that the tortfeasor was "bound to make satisfaction for the injury that he has done." *Id.* The Court acknowledged that the insurer could intervene in the suit and assert its claim for damages, "[b]ut with all this the [owner of the Monticello] has no concern, nor can he defend himself by setting up these equities of others, unless he can show that he has made satisfaction to the party justly entitled to receive the damages." *Id.* at 156.

B. The *Bozeman* Decision

1. *Bozeman*'s Facts and Procedural History

Today, the leading case on the collateral source rule in Louisiana is *Bozeman*. In May 1993, Tommy Bozeman was gravely injured in a car accident. *Id.*, 879 So. 2d at 694. While he was driving, "his right tires dropped off the paved portion of the highway onto the shoulder just as [he] came upon a curve." *Id.* Mr. Bozeman stayed in a hospital until June 1993. *Id.* He then remained in long-term care in a semi-conscious state until his death in August 1996. *Id.*

In November 1993, Mr. Bozeman, with his wife as representative, applied for and was granted Medicaid benefits. *Id.* Ten days later, Mrs. Bozeman filed suit against the State of Louisiana, Department of Transportation and Development ("DOTD"). *Id.*

At the bench trial, both parties introduced a joint exhibit from the Louisiana Department of Health and Hospitals ("DHH"). *Id.* DHH administers the Medicaid program in Louisiana, and this document "detail[ed] the medical services of healthcare providers and the amounts paid by Medicaid for Mr. Bozeman's care." *Id.* The trial court denied DOTD's request for credit for the amounts paid by Medicaid. *Id.* The trial court eventually found DOTD 75% at fault and awarded Mrs. Bozeman about $613,000 in medical expenses, including about $500,000 from the joint DHH exhibit. *Id.*

The Second Circuit affirmed, except on the issue of medical damages. *Id.* at 695 (citation omitted). On this issue, the appellate court remanded for the trial court to fix the amount of special damages for medical expenses in light of the Second Circuit's decision in *Terrell v. Nanda*, 33,242 (La. App. 2 Cir. 5/10/00); 759 So. 2d 1026. *Bozeman*, 879 So. 2d at 695.

On remand, the trial court reduced the amount of medical expenses from roughly $613,000 to about $344,000. *Id.* The trial court "held that the medical expenses 'written off' pursuant to the Medicaid program requirements are not recoverable by this plaintiff." *Id.* The Supreme Court defined a "write off" as follows:

> When an injured plaintiff is a Medicaid recipient, federal and state law require that the healthcare providers accept as full payment, an amount set by the Medicaid fee schedule, which, invariably, is lower than the amount charged by the healthcare provider. The difference between what is charged by the healthcare providers and what is paid by Medicaid is referred to as the "write-off" amount.

Id. at 693. The Plaintiff and DHH appealed, though DHH did so on a separate issue. *Id.* at 695.

The Second Circuit affirmed the trial court but amended the amount of medical damages awarded to about $355,000, "to reflect the correct amount of claims paid and denied by Medicaid." *Id.* at 695. Explaining the Second Circuit's decision, the Supreme Court stated:

> Consistent with the *Terrell* decision, the Court of Appeal held that plaintiff is prevented from recovering those medical expenses that were contractually adjusted or "written-off" by the healthcare providers pursuant to the Medicaid program. The court's reasoning was based on three main factors: (1) the absence of a natural obligation for the "write-off" amount, (2) that no windfall should accrue to either the plaintiff or the defendant when the plaintiff is prohibited from recovering the "write-off" amount, and (3) that federal and state Medicaid statutes dictate that the healthcare providers must accept the payment set by the Medicaid fee schedule as payment in full.

Id.

2. The Supreme Court's Analysis in *Bozeman*

The Supreme Court began with an overview of the collateral source rule. "The collateral source rule is a rule of evidence and damages that is of common law origin, yet embraced and applied by Louisiana courts." *Id.* at 697 (citing Deborah Van Meter, *Louisiana's Collateral Source Rule: Time For A Change?*, 32 LOY. L. REV. 978, 989 (1987)). The Supreme Court had previously cited the Restatement (Second) of Torts § 920A (1979) as "source material for the collateral source rule in *Louisiana Dep't of Transp. and Dev. v. Kansas City Southern. Ry.*, 2002–C–2349 (La. 5/20/03), 846 So. 2d 734, 739." *Id*. Section 920A "codifies the rule" and states:

> (1) A Payment made by a tortfeasor or by a person acting for him to a person whom he has injured is credited against his tort liability, as are payments made by another who is, or believes he is, subject to the same tort liability.
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> (2) Payments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable.

Bozeman, 879 So. 2d at 697 (quoting Restatement (Second) of Torts § 920A). "By 1987, at least forty-four state legislatures, including Louisiana, had introduced bills to reform the collateral source rule," *id.* at 698 (citing Meter, 32 LOY. L. REV. at 1003), but "the Louisiana Legislature has declined to make any statutory changes to the rule," *id.* (citing *Kansas City Southern*, 846 So. 2d at 739).

The Supreme Court then laid out the following definition of the rule:

> 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. *Kansas City Southern Ry., supra,* at 739. Hence, the payments received from the independent source are not deducted from the award the aggrieved party would otherwise receive from the wrongdoer, and, a tortfeasor's liability to an injured plaintiff should be the same, regardless of whether or not the plaintiff had the foresight to obtain insurance. *Id*, at 739–740. As a result of the collateral source rule, the tortfeasor is not able to benefit from the victim's foresight in purchasing insurance and other benefits. *Suhor v. Lagasse,* 2000–1628 (La. App. 4 Cir. 9/13/00), 770 So.2d 422, 423.

Id.

After cataloging other cases in which the collateral source rule has been applied, describing the policies underlying the rule, and discussing the evidentiary aspects of the rule (all three of which are explored in greater detail below), the Supreme Court turned to the issue of damages and the rule. The Court stated:

> The major policy reason for applying the collateral source rule to damages has been, and continues to be, tort deterrence. The underlying concept is that tort damages can help to deter unreasonably dangerous conduct. Tort deterrence has been an inherent, inseparable, aspect of the collateral source rule since its inception over one hundred years ago.

Id. at 700 (footnote omitted). Following a discussion of *The Propeller Monticello* and Louisiana cases demonstrating this policy, the Supreme Court acknowledged that Louisiana and common-law courts have been "inconsistent regarding the medical expenses written-off by healthcare providers pursuant to the Medicaid agreement." *Id*. at 701. The Supreme Court identified three

approaches used in analyzing whether to apply the collateral source rule to Medicaid "write-offs": "(1) reasonable value of services, (2) actual amounts paid, and (3) benefit of the bargain." *Id.* Though the Court analyzed all three approaches, it adopted the third. *Id.*

The "reasonable value of services" approach "is to award plaintiffs the entire amount of the medical expenses that were billed to the plaintiff, including those amounts that were written off by healthcare providers." *Id.* *Bozeman* looked at other courts that adopted this view. *Id.* at 701. For example, the Mississippi Supreme Court had held that there was "no reason why Medicaid benefits should be treated any differently than insurance payments, and they should be subject to the collateral source rule." *Id.* (quoting *Brandon HMA, Inc. v. Bradshaw*, 809 So. 2d 611, 618 (Miss. 2001)). The rationale was more fully explained by comment b to Section 920A of the Restatement, which provides:

> If the plaintiff was himself responsible for the benefit, as by maintaining his own insurance or by making advantageous employment arrangements, the law allows him to keep it for himself. If the benefit was a gift to the plaintiff from a third party **or established for him by law,** he should not be deprived of the advantage that it confers. The law does not differentiate between the nature of the benefits, so long as they did not come from the defendant or a person acting for him.

Bozeman, 879 So. 2d at 701—02 (quoting comment b to Restatement (Second) of Torts § 920A (emphasis by *Bozeman*)). The *Bozeman* plaintiff argued for this approach. *Id.* at 702.

Urged by the defendant, the "actual amounts paid" approach "den[ied] the plaintiff the ability to recover the write-off amounts because the plaintiff did not incur the 'write-off' amount, thus, resulting in a windfall for the plaintiff, if the plaintiff was allowed to recover." *Id.* The DOTD argued that allowing the Plaintiff to recover "would violate the law of compensatory damages" and "would . . . grant the plaintiff a windfall." *Id.* at 703.

The Supreme Court disagreed. It began by citing to several cases from other states holding that, "(i)f there is to be a windfall, it should benefit the injured party rather than the

tortfeasor." *Id.* at 703 (quoting *Rose v. Via Christi,* 276 Kan. 539, 544, 78 P.3d 798 (2003)); *see also Koffman v. Leichtfuss*, 2001 WI 111, 246 Wis. 2d 31, 47, 630 N.W.2d 201; *Five U's Inc. v. Burger King Corp.*, 1998 MT 216, 290 Mont. 452, 455, 962 P.2d 1218). *Bozeman* then stated:

> **Thus, the proper focus of our inquiry is "on the nature of the write-offs vis-a-vis the tortfeasor, rather than vis-a-vis the tort victim,"** as stated by the Louisiana First Circuit Court of Appeal, in *Griffin v. The Louisiana Sheriff's Auto Risk Assoc.*, 1999 CA 2944 (La. App. 1 Cir. 6/22/01), 802 So. 2d 691, 715. The court further determined that when courts approach the problem with this focus,
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> > the application of the collateral source rule makes more sense and is more appropriate. This rationale can best be understood by analyzing the write-offs in two situations: one in which a tortfeasor injures an uninsured victim and the other in which the same tortfeasor, in the same manner and to the same extent, injures an insured victim. Unless the write-offs are considered collateral sources, the tortfeasor would be relieved of his liability to the insured victim to the amount of the write-offs. The argument that there is no underlying obligation for plaintiff to pay the amount of the write-offs and, therefore, the plaintiff should not be allowed to benefit from a non-existent debt, falls because the effect of this reasoning results in a diminution of the tortfeasor's liability vis-a-vis an insured victim when compared with the same tortfeasor's liability vis-a-vis an uninsured victim.

Id., 879 So. 2d at 703 (emphasis added).

Nevertheless, the Supreme Court adopted the "benefit of the bargain" approach, which "award[s] plaintiffs the full value of their medical expenses, including the 'write-off' amount, where the plaintiff has paid some consideration for the benefit of the 'write-off' amounts." *Id.* The Supreme Court cited decisions from Louisiana and other states, explaining:

> Louisiana's First Circuit Court of Appeal adopted this rationale in *Griffin, supra,* when it concluded that the plaintiff's patrimony was continually diminished to the extent that she had to pay premiums in order to secure the benefits of her insurance. [802 So. 2d] at 714. According to the First Circuit, to the extent that the write-offs were procured through the payment of the premiums, they cannot properly be considered a windfall. Rather, the write-off amount was viewed as a benefit to plaintiff's contractual bargain with her insurance provider.
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> Similarly, the Virginia Supreme Court, in *Acuar v. Letourneau*, 260 Va. 180, 531 S.E.2d 316, 322–323 (2000), concluded the following:

> we conclude that Acuar (the tortfeasor) cannot deduct from that full compensation any part of the benefits Letourneau (the victim) received from his contractual arrangement with his health insurance carrier, whether those benefits took the form of medical expense payments or amounts written off because of agreements between his health insurance carrier and his health care providers. Those amounts written off are as much of a benefit for which Letourneau paid consideration as are the actual cash payments made by his health insurance carrier to the health care providers. The portions of medical expenses that health care providers write off constitute 'compensation or indemnity received by a tort victim from a source collateral to the tortfeasor.

Additionally, the Virginia Supreme Court stated that this conclusion is consistent with the purpose of compensatory damages, which is to make the victim whole. The court noted that "the injured party should be made whole by the tortfeasor, not by a combination of compensation from the tortfeasor and collateral sources. The wrongdoer cannot reap the benefit of a contract for which the wrongdoer paid no compensation." *Id.* at 323. Further, the California Supreme Court, in *Helfend v. S. California Rapid Transit District,* 2 Cal. 3d 1, 84 Cal. Rptr. 173, 465 P.2d 61, 66–67 (1970) made specific reference to insurance and other benefits being an investment made by the plaintiff, for which the plaintiff should get the benefit. The California Supreme Court stated the following:

> The collateral source rule expresses a policy judgment in favor of encouraging citizens to purchase and maintain insurance for personal injuries and for other eventualities. Courts consider insurance a form of investment, the benefits of which become payable without respect to any other possible source of funds. If we were to permit tortfeasor to mitigate damages with payments from plaintiff's insurance, plaintiff would be in a position inferior to that of having bought no insurance, because his payment of premiums would have earned no benefit. Defendant should not be able to avoid payment of full compensation for the injury inflicted merely because the victim has had the foresight to provide himself with insurance.

We embrace this reasoning for plaintiffs who have paid some consideration for the collateral source benefits, including the "write-off." In the case *sub judice,* this conclusion would prohibit the plaintiff, a Medicaid recipient, from recovering the "write-off" amount.

Id. at 703—04.

The Supreme Court then distinguished between Medicaid benefits and Medicare and other private insurance. *Bozeman* cited several cases emphasizing that Medicare is

akin to private insurance; "[Medicare] **is financed by compulsory payroll taxes** administered through the Federal Hospital Insurance Trust Fund. Medicare Part A is described as follows: The **insurance program** which provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care." *Bozeman*, 879 So. 2d at 705 (quoting *Hodge v. Middletown Hos. Assoc.*, 91-3232 (1991), 62 Ohio St. 3d 236, 240, 581 N.E.2d 529 (emphasis by *Bozeman*)). Conversely, with respect to Medicaid payments, "**[n]either the beneficiary nor his employer pays premiums or underwrites the costs of the program . . . In short, Medicare Part A is funded by payments made by beneficiaries and their employers, is actuarily determined, and is described by enabling statute as insurance.**" *Id.* (quoting *Hodge*, 62 Ohio St. 3d at 240—41, 581 N.E. 2d 529 (emphasis by *Bozeman*)).

The Louisiana Supreme Court concluded *Bozeman* as follows:

> Care of the nation's poor is an admirable social policy. However, where the plaintiff pays no enrollment fee, has no wages deducted, and otherwise provides no consideration for the collateral source benefits he receives, we hold that the plaintiff is unable to recover the "write-off" amount. This position is consistent with the often-cited statement in *Gordon v. Forsyth County Hospital Authority, Inc.*, 409 F. Supp. 708 (M.D.N.C.1975), *affirmed in part and vacated in part*, 544 F.2d 748 (4th Cir.1976), that "(i)t would be unconscionable to permit the taxpayers to bear the expense of providing **free medical care** to a person and then allow that person to recover damages for medical expenses from a tort-feasor and pocket the windfall." [(]Emphasis added). After careful review, we conclude that Medicaid is a free medical service, and that no consideration is given by a patient to obtain Medicaid benefits. His patrimony is not diminished, and therefore, a plaintiff who is a Medicaid recipient is unable to recover the "write off" amounts. The operative words here are "free medical care," which, again, we hold is applicable to plaintiffs who receive Medicaid, not plaintiffs who receive Medicare or private insurance benefits.
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> . . . In conclusion, Medicaid recipients are unable to collect the Medicaid "write-off" amounts as damages because no consideration is provided for the benefit. Thus, plaintiff's recovery is limited to what was paid by Medicaid. However, in those instances, where plaintiff's patrimony has been diminished in some way in order to obtain the collateral source benefits, then plaintiff is entitled to the benefit

> of the bargain, and may recover the full value of his medical services, including the "write-off" amount.

Id. at 705—06.

C. How the Collateral Source Rule Has Been Applied in Louisiana Case Law

In *Bozeman,* the Louisiana Supreme Court provided an extensive list of situations in which the rule has been applied in Louisiana. Specifically, the Supreme Court stated:

> The collateral source rule has been applied to a variety of factual circumstances, although it typically applies to tort cases involving **insurance payments or other benefits**. In *Kansas City Southern Ry., supra,* this court applied the collateral source rule to **environmental damages under the Louisiana Environmental Quality Act (LEQA).** Louisiana's Third Circuit Court of Appeal recently applied the rule in a **worker's compensation case involving services provided by the Veterans Administration.** *Smith v. Roy O. Martin Lumber Co.,* 03–1441 (La. App. 3 Cir. 4/14/04), 871 So. 2d 661. The rule was applied to **welfare payments** in *Bonnet For and Behalf of Bonnet v. Slaughter,* 422 So. 2d 499, 502 (La. App. 4th Cir. 1982). Further, in *Bryant v. New Orleans Public Serv. Inc,* 406 So.2d 767, 768 (La. App. 4th Cir. 1981), the court opined the following:
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> > The collateral source rule has been held to apply not only where plaintiff **directly purchased insurance against which the plaintiff recovered**, but also where there have been **Medicare payments**—*Womack v. Travelers Insurance Co.,* 258 So.2d 562 (La. App. 1st Cir., 1972); **sick leave and annual leave payments**—*Dunlap v. Armendariz,* 265 So.2d 352 (La. App. 4th Cir., 1972); **retirement pension payments**—*Adam v. Schultz,* 250 So.2d 811 (La. App. 4th Cir., 1971); **free medical services rendered as a professional courtesy**—*Spizer v. Dixie Brewing Co.,* 210 So.2d 528 (La. App. 4th Cir., 1968); **Federal Social Security Benefits**—*Doerle v. State,* 147 So.2d 776 (La. App. 3rd Cir., 1962); **free medical care rendered by the Veteran's Administration**—*Fullilove v. U.S. Casualty Co. of N.Y.,* 129 So.2d 816 (La. App. 2nd Cir., 1961); **insurance paid for by the employer for the employee as a result of a collective bargaining agreement in a F.E.L.A. case**—*Hall v. Minnesota Transfer Ry. Co.,* 322 F. Supp. 92 (D. Minn., 1971); and suits brought under **the Jones Act and Longshoremen's and Harbor Worker's Compensation Act**—*Tipton v. Socony Mobil Oil Co.,* 375 U.S. 34, 84 S. Ct. 1, 11 L .Ed. 2d 4 (1963). In *Bourque v. Diamond M. Drilling Co.,* 623 F.2d 351 (5th Cir., 1980) the court held that an employer tortfeasor could not violate the collateral source rule by applying as a set-off **workmen's compensation benefits received by the former employee from another employer**.

Bozeman, 879 So. 2d at 698—99 (emphasis added).

Similarly, in her concurrence in *Bozeman*, Justice Knoll also cataloged examples of the rule. She wrote:

> 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. *Louisiana Dep't of Transp. and Dev. v. Kansas City S. Ry. Co.*, 02–2349, p. 6 (La.5/20/03), 846 So.2d 734, 739. This holding is not disturbed by today's ruling. There are many and varied origins of collateral sources which may provide compensation for the tort victim's injuries. **In addition to Medicare, Medicaid and insurance benefits, collateral sources can also comprise payment of wages unless for services performed, worker's compensation, unemployment compensation, sick pay and related employee benefit programs, Social Security, pension and retirement funds, and benefits provided gratuitously by private parties or government agencies under compulsion of neither contract nor statute.** 3 *Damages in Tort Actions* § 17.00 (1997). Often an injured person receives gratuitous medical, economic or other assistance from governmental agencies or private benefactors. *Id.*, § 17.41.

Id., 879 So. 2d at 706 (Knoll, J., concurring) (emphasis added).

D. Evidentiary Aspects of the Collateral Source Rule

The above discussion has focused primarily on the relationship between the collateral source rule and damages. However, *Bozeman* recognized that "the collateral source rule is *rule of evidence* and damages." 879 So. 2d at 699 (emphasis added).

Though there was "no dispute . . . from an evidentiary perspective" in *Bozeman*, the Supreme Court did provide guidance on the evidentiary issue. *Id.* at 700. The Court stated:

> From an evidentiary perspective, the rule bars the introduction of evidence that a plaintiff has received benefits or payments from a collateral source independent of the tortfeasor's procuration or contribution. The issue typically arises at trial following the submission of a Motion in Limine. For example, in *Terrell v. Nanda*, 33,242–CA (La. App. 2 Cir. 5/10/00), 759 So.2d 1026, 1028, plaintiffs argued that under the collateral source rule they were entitled to contractually adjusted medical expenses. In conjunction with this argument, plaintiffs filed a Motion in Limine to exclude any evidence of Medicaid payments. *Id.* Similarly, in *Suhor v. Lagasse*, 2000–1628 (La. App. 4 Cir. 9/13/00), 770 So.2d 422, 423, the trial court was called upon to determine what amount of plaintiff's past medical expenses were appropriate to be put into evidence before the jury. Also, in *Kansas City Southern Railway*, *supra*, DOTD argued that under the collateral source rule, the liability of the wrongdoer, Kansas City Southern, should not be

> reduced due to clean-up costs paid by a collateral source, the Federal Highway Administration (FHWA). *Id.* at 739. In response to the assertion that DOTD could not recover the clean-up costs paid by FHWA, DOTD filed a Motion in Limine seeking to withhold from the jury evidence of FHWA's payments. *Id.* at 737.

Id. at 699–700.

Ultimately, a court may bar the introduction of evidence of benefits received from a third party because of the resulting prejudice. *See Francis v. Brown*, 95-1241 (La. App. 3 Cir. 3/20/96); 671 So. 2d 1041, 1046—47. For example, in *Francis*, the Third Circuit held that the trial court erred in allowing the plaintiff to be cross-examined as to payment by her counsel of plaintiff's medical cost. *Id.* Similarly, in *Menson v. Taylor*, 2002-1457 (La. App. 1 Cir. 6/27/03); 849 So. 2d 836, the First Circuit held that held that "the trial judge correctly applied the collateral source rule to exclude evidence of disability payments." *Id.* at 841.

E. *Bozeman*'s Description of the Policies Underlying the Collateral Source Rule

Bozeman also discussed the policies underlying the rule. The Supreme Court explained:

> There are several reasons for the existence of the collateral source rule. The reason most often stated is that the defendant should not recover from outside benefits provided to the plaintiff or procured by the plaintiff. For years the Louisiana courts struggled with the so-called "windfall" or "double-dip" aspect of the collateral source rule only to discover that no "windfall" or "double dip" in fact occurred. No "windfall" or "double dip" occurred because the injured party's patrimony was diminished to the extent that he was forced to recover against outside sources and the diminution of patrimony was *additional* damage suffered by him.
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> For example, if the payment received by plaintiff was from annual leave or sick leave time, then those resources which would have been available to him but for the accident or injury, are no longer available and he has suffered the loss of annual or sick leave time for which he should be recompensed. This same logic applies to pension payments, government benefits, and gratuitous services.
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> In the case of insurance purchased by the plaintiff or deductions made from the plaintiff's paycheck, the plaintiff has paid premiums which are a diminution of his patrimony as that cash would have otherwise been available to him. By going against his own insurance policy, he is diminishing the benefits of that policy which would otherwise be available, he has suffered a diminution of the

> patrimony by premium payments and his rates will rise providing a third area of loss.
>
> Where insurance is provided by the employer, then that fringe benefit is in the nature of deferred compensation. The deferred compensation would have been available to him as cash per paycheck, but for the existence of the deferred compensation plan. Likewise, the benefits of the deferred compensation would have been available but for the injury.
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> Lastly, if the collateral source rule were not applied, then there would be no reason for an individual to purchase insurance. For example, if in a wrongful death case the tortfeasor was allowed a set-off for proceeds from the deceased's life insurance policy, then the deceased's estate suffered the loss not only of the amounts paid as premiums but also for the *use* of the money over the years, so that the deceased's estate could, theoretically, bring an action against the defendant to recover back the set-off amount.

Bozeman, 879 So. 2d at 699 (quoting *Bryant v. New Orleans Public Serv. Inc*, 406 So.2d 767, 768 (La. App. 4th Cir. 1981) (emphasis added by *Bozeman*)).

But it bears repeating that, in its analysis of the relationship between damages and the rule, *Bozeman* emphasized another policy. Specifically, the Court stated:

> The major policy reason for applying the collateral source rule to damages has been, and continues to be, tort deterrence. The underlying concept is that tort damages can help to deter unreasonably dangerous conduct. Tort deterrence has been an inherent, inseparable, aspect of the collateral source rule since its inception over one hundred years ago.

Id. at 700 (footnote omitted). Thus, *Bozeman* highlighted two policy considerations: (1) tort deterrence, and (2) compensation to an injured party. The Supreme Court would crystalize this two-pronged approach in *Bellard*, which is discussed in the next section.

F. Louisiana Supreme Court Cases after *Bozeman*

1. *Bellard v. American Central Insurance Co.*, 2007-1335 (La. 4/18/08); 980 So. 2d 654 – UM Coverage and Workers Compensation Benefits

Bellard provides the Supreme Court's most extensive discussion of the collateral source rule since *Bozeman*. *Bellard* clarifies the competing policy considerations described in *Bozeman*

and, most importantly, provides a framework for approaching cases involving the collateral source rule.

Bellard is a car accident case. The plaintiff, a delivery driver for a buildings materials retailer, was driving a company car when he was rear ended. *Bellard*, 980 So. 2d at 659. After a few more car accidents, the plaintiff filed suit against the tortfeasor and her liability insurer. *Id.* at 660. Later, the plaintiff added his employer's uninsured motorist ("UM") carrier. *Id.* After the UM carrier became the sole defendant, it "filed a motion for summary judgment seeking a declaration that it [was] entitled to a credit for all payments made to [the plaintiff] as workers' compensation benefits." *Id.* at 661. The district court granted the motion, finding that the workers' compensation carrier and UM carrier were solidary obligors, that a payment by one relieves the other to the extent of the credit, and that the collateral source rule did not apply. *Id.* The appellate court reversed, finding that there was no solidary liability and that the collateral source rule applied. *Id.* at 662. The Supreme Court granted writs to resolve a split by the courts of appeal concerning the credit issue as well as to address the damage award. *Id.*

Thus, the first issue before the Supreme Court was "whether an uninsured motorist is entitled to a credit for medical and disability wage benefits paid on behalf of or to an injured worker by the workers compensation insurer." *Id.* at 662—63. The Supreme Court found this "hinge[d] on two inquiries: (1) whether the insurers are solidary obligors; and (2) whether the collateral source doctrine applies." *Id.* at 663. Concerning the latter, the Supreme Court stated:

> If the collateral source doctrine applies, payments received from a source independent of the tortfeasor's procuration or contribution are not deducted from the award the injured plaintiff receives from the tortfeasor and the plaintiff is entitled to recover the same damages from both the employer's uninsured motorist carrier and the workers' compensation insurer.

Id. (citing *Bozeman*, 879 So. 2d at 698). After an extensive discussion, the Supreme Court answered the first question by finding that the UM carrier and workers' compensation insurer were solidary obligors. *Id.* at 663—67.

Turning to the collateral source rule, the Court discussed the general principles of the rule (largely taken from *Bozeman*) then looked at its underlying policies:

> Several public policy concerns support the collateral source doctrine. *Louisiana Department of Transportation and Development*, 02-2349 at 7, 846 So. 2d at 739. The concern most often voiced is that the tortfeasor should not gain an advantage from outside benefits provided to the victim independently of any act of the tortfeasor. *Id.* The objective in this regard is to promote tort deterrence and accident prevention. *Id.* Another concern advanced is that, absent the collateral source rule, victims would be dissuaded from purchasing insurance or pursuing other forms of reimbursement available to them. *Id.*
>
> Of the reasons cited in support of the rule, "[t]he major policy reason for applying the collateral source rule to damages has been, and continues to be, tort deterrence." *Bozeman*, 03-1016 at 12, 879 So. 2d at 700. In other words, the rule is grounded in the belief that the tortfeasor should not profit from the victim's prudence in obtaining insurance, and that reducing the recovery by the monies paid by a third party would hamper the deterrent effect of the law. *Bozeman*, 03-1016 at 15-16, 879 So. 2d at 701-702.
>
> One troubling aspect of the collateral source rule with which courts have struggled is the double recovery or windfall that might arise as a consequence of the victim's receipt of an outside payment. The purpose of tort damages is to make the victim whole. This goal is thwarted, and the law is violated, when the victim is allowed to recover the same element of damages twice. [(citations omitted)] As explained by this court in *Bozeman*, 03-1016 at 10, 879 So. 2d at 699:
>
> > For years the Louisiana courts struggled with the so-called "windfall" or "double-dip" aspect of the collateral source rule only to discover that no "windfall" or "double dip" in fact occurred. No "windfall" or "double dip" occurred because the injured party's patrimony was diminished to the extent that he was forced to recover against outside sources and the diminution of patrimony was *additional* damage suffered by him. [Emphasis in original.]

Bellard, 980 So. 2d at 668.

The Supreme Court then discussed *Bozeman* and how it "addressed the conflict that is raised between the two guiding principles of tort damages – to deter wrongful conduct and to make the innocent victim whole – when the collateral source rule is applied in instances in which an actual windfall or double recovery would be realized by the injured party." *Id.* The *Bellard* court explained how, in *Bozeman*:

> [The Court] reasoned that whether the collateral source rule applies depends to a certain extent upon whether the victim has procured the collateral benefits for himself or has in some manner sustained a diminution in his or her patrimony in order to secure the collateral benefits such that he or she is not merely reaping a windfall or double recovery.

Id. at 669. The Supreme Court then brought together these competing considerations as follows:

> **After *Bozeman*, two primary considerations guide our determination with respect to the collateral source rule. The first consideration is whether application of the rule will further the major policy goal of tort deterrence. The second consideration is whether the victim, by having a collateral source available as a source of recovery, either paid for such benefit or suffered some diminution in his or her patrimony because of the availability of the benefit, such that no actual windfall or double recovery would result from application of the rule.**

Id. (emphasis added).

Applying these principles, the Court found that the collateral source rule did not apply. *Id.* First, since the victim's UM carrier sought a credit, "applying the . . . rule in this instance will not serve the goal of tort deterrence." *Id.* The tortfeasor would not "receive any benefit or reduction in liability as a result of the credit," and the credit would provide no "disincentive for the tortfeasor to conform her conduct to standards of reasonableness." *Id.* Thus, the "major policy reasons" for the rule were not present. *Id.*

Second, the plaintiff would receive a windfall or double recovery without having any diminution in his patrimony for the workers' compensation benefits. *Id.* at 669—70. There was no right of reimbursement or subrogation for the employer and/or its workers' compensation

insurer from the UM carrier, so they could not seek reimbursement from the UM carrier for these amounts. *Id.* at 670. Moreover, "unlike sick leave, annual leave, or employer-provided health insurance, workers' compensation benefits cannot be considered a fringe benefit in the nature of deferred compensation that would otherwise be available to the plaintiff but for his injury." *Id.* Rather, "workers compensation benefits are required by law," and that law bars an employer from seeking the cost of workers' compensation insurance from an employee. *Id.* (citing La. Rev. Stat. § 22:1163). Lastly, the plaintiff had "not given consideration for the workers' compensation benefits by waiving the right to sue his employer for damages because he has no cause of action against his employer who is without fault." *Id.*

The Supreme Court concluded:

> In essence, the situation of the plaintiff in this case is not unlike that of the Medicaid recipient in *Bozeman*. That case instructs that where, as here, the plaintiff pays no enrollment fee, has no wages deducted, and otherwise provides no consideration for the collateral source benefit, the collateral source rule does not apply. *Bozeman*, 03-1016 at 21, 879 So. 2d at 705. This result is especially called for where, as in this case, application of the rule would allow plaintiff to receive a windfall without providing a commensurate deterrent effect, and thereby undermine a major policy concern supporting the collateral source rule.

Id. The Court also noted:

> In reaching this conclusion, we remain mindful of the admonition that the focus of our analysis when examining the collateral source rule should be on the nature of the off-set or credit *vis-a-vis* the tortfeasor rather than the tort victim. *Bozeman*, 03-1016 at 18, 879 So. 2d at 703. Adherence to such an analysis in this instance underscores the fact that allowing the credit to the employer's uninsured motorist carrier will not inure to the benefit of the tortfeasor, will not allow the tortfeasor to receive a "windfall," and will not undermine the deterrent effect of tort law.

Id. at 670 n. 6. As the Supreme Court held in *Fertitta v. Allstate Insurance Company*, 462 So.2d 159 (La. 1985), "the collateral source rule does not apply in this instance to override the principles of solidarity expressly set forth in the civil code." *Bellard*, 980 So. 2d. at 670—71.

Thus, the UM carrier was entitled to a credit for the medical expenses paid by the plaintiff's employer and workers' compensation carrier. *Id.* at 675.

Thus, *Bellard* lays out and then applies the appropriate standard in analyzing collateral source rule issues. First, a court must consider "whether application of the rule will further the major policy goal of tort deterrence." Second, it must consider whether the victim that has a collateral source available "either paid for such benefit or suffered some diminution in his or her patrimony because of the benefit, such that no actual windfall or double recovery would result from application of the rule." The Supreme Court has applied this approach in cases after *Bellard*, though it has varied in its emphasis of each factor.

2. *Cutsinger v. Redfern*, 2008-2607 (La. 5/22/09); 12 So. 3d 945 - UM Coverage and Workers Compensation Benefits

Cutsinger also involved the relationship between UM payments, workers compensation, and the collateral source rule. *Cutsinger* was an automobile accident case. *Id.* at 947. The plaintiff filed suit against the tortfeasor, her alleged automobile liability insurer, (USAgencies), and the plaintiffs' own UM carrier. *Id.* When the accident occurred, the plaintiff was in the course and scope of her employment, and she was later given workers' compensation benefits by her employer. *Id.* USAgencies was dismissed on summary judgment, so the tortfeasor was uninsured when the accident occurred. *Id.*

The plaintiff moved for summary judgment on the question of liability and on the issue of whether UM carrier was "entitled to a credit" or was "allowed to reduce the [UM] coverage afforded plaintiff by any payments that may [have been] made by plaintiff's employer or its workers' compensation carrier." *Id.* at 948. The trial court granted summary judgment on both issues. *Id.*

The UM carrier appealed the second issue, but the Third Circuit affirmed. *Id.* The appellate court distinguished *Bellard* by finding that "because the plaintiff herself, and not her employer, paid for the uninsured motorist coverage, the collateral source rule applies and [the UM carrier] cannot reduce the uninsured motorist benefits by the amount of workers' compensation benefits paid to plaintiff." *Id.*

The Supreme Court turned to the plaintiff's UM policy and found it clear and unambiguous; under it, "any damages for bodily injury for which the uninsured tortfeasor is liable that are also paid or payable to the insured under any workers' compensation law, such as lost wages and medical benefits, will not be paid under the insured's uninsured motorist coverage." *Id.* at 950.

The plaintiff argued that the policy was in "derogation of state law" and was a "clear violation of public policy," but the Supreme Court disagreed. *Id.* at 950. The Court analyzed *Bellard* and concluded that, for the same reasons, "the uninsured motorist carrier and the workers' compensation insurer are solidary obligors." *Id.* at 951. The Supreme Court also found that the "underlying purpose of the uninsured motorist law, which is to promote and effectuate complete reparation, no more or no less, is not hindered by the application of solidarity in this instance." *Id.* at 952 (citation and quotation omitted).

The Supreme Court then turned to the collateral source rule. After an extensive review of the *Bellard* decision and a specific description of the two policy considerations from *Bellard*, the Supreme Court concluded that the Third Circuit viewed *Bellard* "too narrowly." *Id.* at 953—54. The Supreme Court explained:

> **While it is important to consider whether plaintiff paid for the collateral source or suffered some diminution in her patrimony due to the availability of the benefit to determine whether a double recovery would result from application of the rule, this consideration alone is not the determinative**

> **factor in deciding whether the collateral source rule applies. The collateral source rule exists to prevent the tortfeasor from benefitting from the victim's receipt of monies from independent sources. In this way, the collateral source rule furthers the major policy of tort deterrence.** In this case, the tortfeasor is not requesting the credit for workers' compensation benefits paid. The tortfeasor will reap no benefits if the collateral source rule is not applied and the uninsured motorist carrier is allowed to reduce its payments to plaintiff by the amount of workers' compensation benefits she received. The tortfeasor's position will not change whether or not the credit is allowed. Thus, application of the collateral source rule would not further the major policy goal of tort deterrence.
>
> Turning to the consideration of whether the victim paid for the collateral source such that no actual double recovery would result from application of the rule, we note that in *Bellard* we considered the collateral source to be the workers' compensation benefits since it was the uninsured motorist carrier, rather than the tortfeasor or the plaintiff, who sought the credit. In the instant case, plaintiff did not sustain a diminution in her patrimony because of the availability of workers' compensation benefits and could therefore be said to receive a windfall or double recovery of lost wages and medical benefits if the collateral source rule is applied to prohibit the credit for those benefits paid by the workers' compensation insurer. Here, no right of reimbursement or subrogation exists in favor of the workers' compensation insurer to prevent a double recovery. The terms of the uninsured motorist coverage purchased by plaintiff provide that there is no uninsured motorist coverage to the extent it benefits any workers' compensation insurance company. This policy language has been held to be enforceable and not against public policy. *Travelers Ins. Co. v. Joseph*, 95–0200, p. 11 (La. 6/30/95), 656 So. 2d 1000, 1004 ("[N]o statutory provision or policy consideration precludes a UM carrier from contracting to exclude liability for compensation reimbursement."). Further, workers' compensation benefits are required by law and the law prohibits an employer from directly or indirectly assessing an employee with the cost of workers' compensation insurance. La. R.S. 23:1163. *See also Bellard*, 07–1335 at p. 22, 980 So. 2d at 670.

Id. at 954 (emphasis added)

The Supreme Court also rejected the Plaintiff's argument that she paid for her own UM coverage and thus did not receive a windfall. *Id.* The Court disagreed that she paid for UM coverage for "benefits such as lost wages and medical payments previously paid by her employers' workers' compensation insurer or that applying the collateral source rule and disallowing the credit would not result in a windfall or double recovery." *Id.* at 954—55. Here, the UM policy had language specifically stating that any amount owed under UM coverage

would be reduced by any amount paid under workers' compensation benefits. *Id.* at 955. Thus, "when she paid the premium for the uninsured motorist coverage, she did not pay for it to cover benefits paid by the workers' compensation insurer." *Id.*

The Supreme Court concluded:

> Application of the collateral source rule in this case would not further the major policy goal of tort deterrence and we cannot find that application of the rule would not result in a windfall or double recovery to plaintiff. Further, this court has specifically stated that the collateral source rule does not apply to override the principles of solidarity expressly provided by our Civil Code. In light of these facts, we conclude the collateral source rule should not be applied in this case.

Id. at 955. Thus, the appellate court decision was reversed, and the UM carrier was entitled to reduce its payments by the amounts paid on behalf of the plaintiff by the workers' compensation insurer. *Id.* at 956.

3. *Benoit v. Turner Industries Group, L.L.C.*, 2011-1130 (La. 1/24/12); 85 So. 3d 629 (per curiam) – Medicaid "Write Offs" in Workers' Compensation Proceeding

Benoit involves Medicaid "write offs" in the context of workers' compensation proceedings. The claimant "sought indemnity benefits and medical expenses compensation against his employer" after he allegedly developed acute myeloid leukemia during his decades of working with chemicals. *Benoit*, 85 So. 3d at 630. The Office of Workers' Compensation ("OWC") awarded him medical expenses in the amount of about $625,000. *Id.* The appellate court affirmed. *Id.* at 631. The employer again appealed the award of medical expenses. *Id.*

Of the total medical expenses claimed, about $422,000 were written off by the Medicaid program, and the rest was paid by Medicaid. *Id.* The employer argued the claimant was not entitled to either. *Id.*

As to the amount paid by Medicaid, the Supreme Court found that the OWC erred in making this award. The central issue was an interpretation of La. Rev. Stat. 23:1212, which provided:

> A. Except as provided in Subsection B, payment by any person or entity, **other than a direct payment** by the employee, a relative or friend of the employee, or **by Medicaid** or other state medical assistance programs of medical expenses that are owed under this Chapter, **shall extinguish the claim against the employer or insurer for those medical expenses**....
>
> B. Payments by Medicaid or other state medical assistance programs **shall not extinguish these claims and any payments by such entities shall be subject to recovery by the state** against the employer or insurer. [emphasis added]

Id. (emphasis in original). After reviewing the history of the statute, the Supreme Court concluded:

> Reading the statute as a whole, it is clear that under La. R.S. 23:1212(A), the payment of medical expenses by Medicaid extinguishes any claim by the employee against the employer for those expenses. La. R.S. 23:1212(B) carves out a narrow exception, whereby the state is granted a right to recover these expenses from the employer.

Id. at 632. Thus, the "direct payment . . . of medical expenses by Medicaid extinguished any claim the claimant may have had to recover these amounts from" the employer. *Id.* at 632—33.

The next issue was whether the claimant could recover the remaining amount written off by Medicaid. *Id.* at 633. The employer argued that *Bozeman* precluded recovery for this amount. *Id.* The claimant asserted, among other things, that *Bozeman* was distinguishable because *Bozeman* was a tort action, not a workers' compensation proceeding. *Id.* at 633—34.

The Supreme Court rejected the Plaintiffs' argument and found in favor of the employer. The Supreme Court explained:

> Having found no conflict between the Medicaid write-off process and the workers' compensation law, we find the principles enunciated in *Bozeman* are equally applicable in a workers' compensation context. As we explained in *Bozeman,* Medicaid is a free medical service, and no consideration is given by a

> patient to obtain Medicaid benefits. As a result, claimant would receive an improper windfall if he was allowed to recover for medical expenses which have been reduced by health care providers as a result of their contractual arrangements with Medicaid. Such double recovery of damages is not permitted under Louisiana law. *See Gagnard v. Baldridge,* 612 So. 2d 732, 736 (La. 1993) ("Double recovery would be in the nature of exemplary or punitive damages which are not allowable under Louisiana law unless expressly provided for by statute"). Accordingly, the portion of the OWC's judgment permitting claimant to recover the written off amount of $422,043.59 is erroneous and must be reversed

Id. at 635.

It's worth noting that Justice Johnson and Justice Knoll each wrote stinging dissents. Justice Johnson explained how the claimant was denied the benefit of the workers' compensation scheme and suffered a diminution to his patrimony by losing the ability to choose his doctor and having to travel long distances for treatment. *Id.* at 638 (Johnson, J., dissenting). She also discussed the bad policy of the per curiam opinion; "The opinion gives [the employer], and indeed all employers within the State an incentive to deny claims, deny treatment, and place the burden on the State to take care of these injured employees." *Id.* at 640 (Johnson, J., dissenting). Justice Knoll emphasized how tort law is distinct from the workers' compensation statutory scheme and policies, so *Bozeman* is inapplicable. *Id.* at 643 (Knoll, J., dissenting). Justice Knoll also explained that the claimant didn't get a windfall; the employer did. *Id.* at 644 (Knoll, J., dissenting). The employer "shirk[ed] its duties under the Worker's Compensation Act" and "profited" by over $625,000, and the per curiam holding "creates a perverse incentive for other companies to do the same." *Id.* (Knoll, J., dissenting). Justice Knoll concludes, "Given the results of today's opinion, the Legislature should again address this inequitable result that fosters perverse incentives by unscrupulous employers." *Id.* (Knoll, J., dissenting).

The majority in *Benoit* clearly found that the case involved a straightforward application of *Bozeman*. However, the dissents provide strong policy reasons why *Bozeman* may not be

appropriate in this situation. Ultimately, Justice Knoll is correct; given the Supreme Court's ruling, the best and, indeed only, solution is a legislative one.

4. *Prest v. Louisiana Citizens Property Insurance Corp.*, 2012-0513 (La. 12/4/12); 125 So. 3d 1079 – Settlement with Insurer and Failure to Obtain Coverage Claim

Prest involved a brief discussion of the policy considerations discussed in *Bozeman* and *Bellard*. "In October 2003, Kennedy, Lewis, Renton & Associates, Inc. ('KLR'), an insurance agency in southeastern Louisiana, secured a property insurance policy with Louisiana Citizens Property Insurance Corporation ('Citizens')" for the plaintiffs on property located in Plaquemines Parish. *Prest*, 125 So. 3d at 1082.

Following Hurricane Ivan, the Plaintiffs repaired and built new constructions on the property. *Id.* Since they had been underinsured, they also requested increased coverage on four buildings on the property in July 2005. *Id.* An agent with KLR "sent a written request for the increased coverage to Citizens by certified mail." *Id.* Though the request was received, the agent knew that KLR needed "to send multiple written communications to ensure Citizens made the policy change requested." *Id.* at 1083. Nevertheless, KLR never followed-up, despite its policy requiring it to do so. *Id.*

Later, in August 2005, the plaintiffs completed more additions and renovations on the buildings and sought a further increase on some of the buildings. *Id.* KLR's agent sent the request to Citizens by regular mail. *Id.* Again, KLR did not follow-up. *Id.* The agent heard nothing from Citizens but nevertheless told the Plaintiffs they were insured. *Id.*

Hurricane Katrina hit and damaged the buildings. *Id.* Believing they had the increased coverage, plaintiffs sought recovery from Citizens. *Id.* Citizens rejected the claim and paid only the original amount of coverage. *Id.*

The plaintiffs filed suit against Citizens seeking full payment under the policies, including the increases, attorney's fees, and penalties. *Id.* at 1084. Alternatively, they sought recovery from KLR for negligence "for its inaction in failing to procure the requested insurance coverage from Citizens or another insurer, and for its inaction in failing to notify Plaintiffs that their timely requests for coverage and coverage increases had been rejected or were not otherwise completed." *Id.*

After pretrial discovery, the plaintiffs settled with Citizens, with no admission of liability by them. *Id.* The plaintiffs also gave up their rights in four class actions against Citizens after Hurricane Katrina, and they also settled their claim for attorney fees and penalties." *Id.* The plaintiffs reserved their negligence claims against KLR. *Id.*

After a trial of those claims, the trial court found KLR negligent and awarded, among other things, special damages "for the attorney fees and costs which they expended in connection with their suit against Citizens, and for the delay in receiving the total amount of the insurance policy limits." *Id.*.

The appellate court affirmed in part. *Id.* It found that the trial court erred in finding KLR negligent for the July 2005 request. *Id.* The appellate court also reduced the special damage award, specifically with respect to delay damages. *Id.*

The Supreme Court affirmed on the issue of liability. *Id.* at 1085—87. The Supreme Court found that "KLR failed to exercise reasonable diligence in attempting to procure insurance coverage for its clients in August 2005, and was, therefore, negligent in this regard." *Id.* at 1087.

The Supreme Court also specifically addressed the collateral source rule. KLR argued that plaintiffs recovered nearly twice the value of the property and that, as a result, they were

"not entitled to more money from KLR." *Id.* at 1087—88. The Supreme Court rejected this argument, explaining:

> [T]he claims which Plaintiffs bring against KLR are not based on their insurance contract, but rather are based on KLR's negligence in failing to obtain requested insurance coverage or to inform Plaintiffs they were not actually covered by the amount of insurance they requested. As such, KLR's argument appears contrary to the collateral source rule. 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." *Bozeman v. State*, 2003–1016, p. 9 (La. 7/2/04); 879 So. 2d 692, 698, *citing Louisiana Dept. of Transp. and Dev. v. Kansas City Southern Ry.*, 2002–2349, p. 6 (La. 5/20/03); 846 So. 2d 734, 739. As explained in *Bozeman*, "the payments received from the independent source are not deducted from the award the aggrieved party would otherwise receive from the wrongdoer, and, a tortfeasor's liability to an injured plaintiff should be the same, regardless of whether or not the plaintiff had the foresight to obtain insurance." *Id., citing Kansas City Southern Ry.*, 2002–2349, p. 6; 846 So. 2d at 739–740. "As a result of the collateral source rule, the tortfeasor is not able to benefit from the victim's foresight in purchasing insurance and other benefits." *Id.*
>
> Thus, the monies received by the Plaintiffs from Citizens in their settlement does not shield KLR from the payment of damages for its negligence, if the Plaintiffs suffered additional damages.

Id. at 1088. Moreover, the Supreme Court elaborated on the issue when it found no abuse of discretion on the award of special damages:

> KLR argues Plaintiffs sustained no losses because Citizens ultimately settled with Plaintiffs for the full amount of the contested insurance policy proceeds. The record shows, contrary to KLR's argument, Citizens never acknowledged its liability to Plaintiffs. The fact that Citizens ultimately settled the lawsuit against it for the increased coverage limits does not mean the requested insurance coverage was, somehow retroactively, procured. Nor does the settlement negate the fact that Plaintiffs suffered additional damages, beyond the policy limits of their insurance coverage. Plaintiffs were still obliged to file suit and participate in contentious litigation in order to recover policy limits they believed they already had, but did not, due to KLR's negligence either in failing to ensure coverage was actually bound, or in failing to alert Plaintiffs they were not covered in the requested amounts.
>
> In this case, "... the injured party's patrimony was diminished to the extent that he was forced to recover against outside sources and the diminution of patrimony was additional damage suffered by him." *Bozeman*, 2003–1016, p. 10; 879 So. 2d

> at 699, *citing Bryant v. New Orleans Public Serv. Inc.*, 406 So. 2d 767, 768 (La. App. 4 Cir. 1981). Consequently, the interest on the amount of insurance proceeds in dispute and the attorney fees expended in litigating the case against the insurance company (and not the attorneys' fees expended in the litigation against KLR) were the proper measure of damages sustained by Plaintiffs for the negligence of KLR.

Id. at 1091.

5. *Hoffman v. Travelers Indemnity Co. of America,* 2013-1575 (La. 5/7/14); 144 So. 3d 993 – Medical Expenses Reduced Because of Pre-Negotiated Rates With An Insurer

Hoffman v. Travelers Indemnity Co. of America touches on the collateral source rule. In *Hoffman*, the plaintiff was involved in an automobile accident and obtained medical treatment at a medical center. 144 So. 3d at 995. Her expenses totaled $713.67, but, because she was covered by her parent's health insurance policy, the medical center reduced the charges to $485.29. *Id.* The plaintiff paid the $485.29, and the medical center never sought payment for $713.67. *Id.*

Plaintiff sued Travelers, which had issued her an automobile insurance policy. *Id.* Plaintiff sought from Travelers the full $713.67. *Id.*

The central issue in the case was proper interpretation of "incurred" as used in the Traveler's policy. *Id.* at 997. The Supreme Court found "the term 'incurred' in the medical payments provision of the Travelers' policy unambiguous, and conclude that an expense is 'incurred' when one has paid it or become legally obligated to pay it." *Id.* The Court further found that, because the medical center had pre-negotiated rates with the insurer, the plaintiff "was only legally obligated to pay $485.29." *Id.* at 1000. Because she bore no liability for any amount over the $485.29 paid to the medical center, "she did not incur the full medical expenses of $713.67." *Id.* Thus, Travelers "fully performed under the insurance contract and [was] entitled to summary judgment." *Id.* at 1001.

In reaching this decision, the Supreme Court distinguished two cases relied upon by the plaintiff: *Thomas v. Universal Life Insurance Co.*, 201 So. 2d 529 (La. App. 3 Cir. 1967), and *Niles v. American Bankers Insurance Co.*, 229 So. 2d 435 (La. App. 3 Cir. 1969), explaining:

> Thus, in both *Thomas* and *Niles*, the plaintiffs were found to have incurred the expenses because the charges were billed to the plaintiffs, and plaintiffs were legally responsible for those charges. Plaintiffs' failure to pay the charges was not due to a lack of legal responsibility, but, rather, because a third party paid the expenses on their behalf. By contrast, [the plaintiff here] was charged and billed for $485.29 and she personally paid that amount. We find the rationale underlying the holdings of *Thomas* and *Niles* more akin to cases involving the collateral source rule. Viewed in this light, *Thomas* and *Niles* do not address the question of whether [the plaintiff here] can recover more in expenses than [the medical center] charged and accepted from her as full payment, and their rulings are inapposite here.

Id. at 1000–01 (footnote omitted).

6. *Hoffman v. 21st Century North America Insurance Co.*, 2014-2279 (La. 10/2/15); --- So. 3d ----; 2015 WL 5776131 – Medical Expenses "Written Off" for Attorney's Negotiated Discount

Hoffman v. 21st Century North America Insurance Co. returns to the policies outlined in *Bozeman* and *Bellard*. It also represents the Supreme Court's latest decision on the collateral source rule.

Hoffman v. 21st Century arose from a car accident in Baton Rouge. 2015 WL 5776131, at *1. The plaintiff's vehicle was rear-ended by another car. *Id.* The plaintiff sued the other driver and her insurer. *Id.* The defendant was found to be 100% at fault, and the plaintiff was awarded about $7,000 in damages, including $2,478 for special medical expenses.

The plaintiff appealed, arguing that the special damages were too low. *Id.* The First Circuit affirmed. *Id.* The issue before the Supreme Court involved the award for medical expenses. *Id.* The plaintiff had introduced medical bills for two MRIs totaling $3,000, but he was only awarded $475.00 per MRI for a total of $950. *Id.* The medical statement showed "$950 in payments from the attorney, and a bill 'adjust [sic]' in the amount of $2050." *Id.* The itemized

portion included a note indicating an "ATT W/O" of $1,025.00 for each MRI. *Id.* The trial judge noted that the plaintiff's attorney had "an arrangement" with the health care provider. *Id.* The plaintiff argued that, under the collateral source rule, he was "entitled to the total billed amount, including the portion of the bill that was 'adjusted,' or 'written-off,' and his recovery is not limited to merely the portion actually paid." *Id.* The Supreme Court granted certiorari to determine "whether the collateral source rule applies to the 'written-off' portion of a medical bill when the plaintiff's attorney negotiated the discount." *Id.*

After discussing the history of the rule and its underlying policy factors, the Supreme Court explained:

> While the collateral source rule has been applied in a variety of circumstances, it most typically has been applied in tort cases involving insurance payments and other benefits. *Bozeman,* 03–1016, p. 9, 879 So. 2d at 698. As we explained in *Bellard v. American Cent. Ins. Co,* 07–1335, p. 19, 980 So. 2d 654, 668, the courts have struggled with the question of double recovery or windfall that might arise as a consequence of the victim's receipt of an outside payment. "Double recovery would be in the nature of exemplary or punitive damages, which are not allowable under Louisiana law unless expressly provided by statute." *Gagnard v. Baldridge,* 612 So. 2d 732, 736 (La. 1993). The purpose of tort damages, we noted in *Bellard,* is to make the victim whole, and such a purpose is thwarted, and the law is violated, when the victim is allowed to recover the same element of damages twice. *Id.* This court in *Bozeman* resolved the question to find that no "windfall" or "double-dipping" will occur when "the injured party's patrimony was diminished to the extent that he was forced to recover against outside sources and the diminution of patrimony was *additional* damage suffered by him." *Bellard,* p. 19, 980 So. 2d at 668 (quoting *Bozeman,* p. 10, 879 So. 2d at 699) (emphasis in original).
>
> In *Bozeman,* the issue before us was whether the collateral source rule applies to medical expenses "written off" or contractually adjusted by healthcare providers pursuant to the federal Medicaid program, under which no consideration is provided by the recipient for the receipt of Medicaid benefits. *Bellard,* p. 20, 980 So. 2d at 668–69. The *Bozeman* court held Medicaid recipients may not collect the Medicaid "write-offs" as damages, because no consideration was given for the benefit. 03–1016, p. 22, 879 So. 2d at 705–06. Ultimately, "in holding the Medicaid recipient is unable to collect the Medicaid 'write-off' as damages, [in *Bozeman*] we rejected a traditional application of the collateral source rule in favor of a rule more narrowly tailored to better conform with the compensatory

> goal of tort recovery." *Id.* That goal of Louisiana tort recovery is set forth in Louisiana Civil Code article 2315: "Every act whatever of man that causes damage to another obliges him by whose fault it happened to repair it." Thus, in both *Bozeman* and *Bellard*, we emphasized a fundamental consideration for application of the collateral source rule, in addition to tort deterrence, is "whether the victim, by having a collateral source available as a source of recovery, either paid for such benefit or suffered some diminution in his or her patrimony because of the availability of the benefit, such that no actual windfall or double recovery would result from application of the rule." *Bellard*, 07–1335, pp. 20–21, 980 So. 2d at 669. *See also Cutsinger v. Redfern*, 08–2607 (La. 5/22/09), 12 So. 3d 945.

Id. at *3.

The Supreme Court held that "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." *Id.* at *4. The Court explained:

> First, allowing the plaintiff to recover an amount for which he has not paid, and for which he has no obligation to pay, is at cross purposes with the basic principles of tort recovery in our Civil Code. The wrongdoer is responsible only for the damages he or she has caused. La. Civ. Code art. 2315. The plaintiff has suffered no diminution of his patrimony to obtain the write-off, and, therefore, the defendant in this case cannot be held responsible for any medical bills or services the plaintiff did not actually incur and which the plaintiff need not repay.

Id. Allowing the plaintiff to recover more than the $950 for the MRIs "would amount to a windfall and force the defendant to compensate the plaintiff for medical expenses the plaintiff has neither incurred nor is obligated to pay." *Id.*

Second, the Supreme Court rejected the "plaintiffs' argument that consideration for the benefit is given for attorney-negotiated medical discounts by virtue of the contractual obligation of the plaintiff to pay attorney fees, albeit only in the event of recovery." *Id*. at *5. The tort victim has no right to recover attorney fees, and a defendant is generally not obligated to pay them; therefore, the payment of attorney fees is not *additional* damage to the plaintiff's patrimony. *Id*.

Third, the Supreme Court also "adopt[ed] a bright-line rule that such attorney-negotiated discounts do not fall within the ambit of the collateral source rule because to do otherwise would invite a variety of evidentiary and ethical dilemmas for counsel." *Id.* If the rule did apply to attorney-negotiated discounts, it would open the door for inquiry into the attorney-client relationship to uncover a "diminution in patrimony." *Id.* The attorney might also "run afoul" of his duty to not knowingly make false statements of material fact to third persons. *Id.*

Though the Supreme Court did not find authority directly on point, it indicated that "at least one court has thoroughly considered whether the collateral source rule applies to discounted medical bills and has concluded it does not." *Id.* "In *Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal. 4th 541, 548–49, 129 Cal. Rptr. 3d 325, 257 P.3d 1130 (2011), the court held the collateral source rule should not expand the scope of economic damages to include expenses the plaintiff never incurred." *Id.* Thus, in *Howell*, the plaintiff was not entitled to recover the full charges on a medical bill when the health care provider waived a significant portion "pursuant to an agreement with her insurer"; "the plaintiff did not incur, nor was she otherwise obligated to pay, the full charges presented on the medical bill, and therefore the collateral source rule did not apply." *Id.* (citing *Howell*, 52 Cal. 4th at 566, 129 Cal. Rptr. 3d at 343, 257 P.3d at 1145).

The Supreme Court concluded:

> In the present case, [the plaintiff] did not incur any additional expense in order to receive the attorney-negotiated "write-off," nor has he suffered any diminution in his patrimony. Therefore, he cannot receive the advantage of the collateral source rule. *Bozeman, supra.* Additionally, allowing the plaintiff to recover expenses he has not actually incurred himself, and for which he has no obligation to pay, is contrary to Louisiana Civil Code article 2315. Because [the plaintiff] did not actually incur the "written-off" portion of the charges, the collateral source rule does not apply. We thus find the appellate court did not err in determining that [the Plaintiff] was entitled to reimbursement of $950.00, the actual amount paid

> to and accepted by the medical provider, as opposed to the initial charged amount of $3,000.00.

Id. at *6.

In sum, the *Hoffman v. 21st Century North America Insurance Co.* reiterates the two-prong approach to the collateral source rule: tort deterrence and compensation for diminutions to a party's patrimony. Further it demonstrates that other policies can be considered in determining whether to apply the collateral source rule; just as Justices Johnson and Knoll sought to advance the policies of the workers compensation law in *Benoit*, so too did *Hoffman* consider policies underlying an attorney's ethical duties.

G. Recent Developments in Louisiana Appellate Courts[2]

This section provides brief summaries of appellate court decisions from the past few years dealing with the collateral source rule. For ease of reference, they are organized by topic.

Balanced Billing Act: In *Rabun v. St. Francis Medical Center Inc.*, 50,849 (La. App. 2 Cir. 8/10/16); --- So. 3d ----; 2016 WL 4210972, *on reh'g in part,* 50,849 (La. App. 2 Cir. 11/23/16); --- So. 3d ----; 2016 WL 6892840, the plaintiff was injured in a car accident caused by a third party. *Id.*, 2016 WL 4210972, at *1. She received care at a medical center. *Id.*

The plaintiff had a health insurance policy with United Healthcare. *Id.* Under the contract, the plaintiff "paid premiums to United in exchange for discounted health care rates." *Id.*

[2] This section focuses only on Louisiana appellate court decisions applying Louisiana state law. However, we note that there are recent decisions by the United States Fifth Circuit that involve the collateral source rule in admiralty cases. These decisions include *Deperrodil v. Bozovic Marine, Inc.*, No. 16-30009, 2016 WL 6810728, at *4—*6 (5th Cir. Nov. 17, 2016) (holding that the collateral source rule applied; that the negligent owner and operator of a vessel was liable for the medical expenses paid by the injured plaintiff's employer's LHWCA insurer; but that the plaintiff could only recover those amounts actually paid, not the expenses billed (but not paid)), and *Manderson v. Chet Morrison Contractors, Inc.*, 666 F.3d 373, 380—82 (5th Cir. 2012) (holding that "the relevant amount [of cured owed] is that needed to satisfy the seaman's medical charges. This applies whether the charges are incurred by a seaman's insurer on his behalf and then paid at a written-down rate, or incurred and then paid by the seaman himself, including at a non-discounted rate. Thus, in [the plaintiff's] case, regardless of what his medical providers charged, those charges were satisfied by the much lower amount paid by his insurer. Consequently, the district court erred by awarding the higher, charged (but *not* totally paid) amount.").

The discounted rates were available pursuant to a member provider agreement under which United secured from the medical center discounted charges for the insured (also known as "contracted reimbursement rates"). *Id.*

The medical center decided to attach a medical provider's lien against any settlement proceeds the plaintiff received for the accident. *Id.* The center sent the plaintiff's attorney a copy of the lien, and the attorney requested that the center file a claim with United to recover payment. *Id.* The center did so, but the claim was denied as untimely. *Id.*

The plaintiff filed a class action against the medical center claiming that it "was required to submit all claims for medical bills to United for the contracted rate." *Id.* The plaintiff asserted that the center's "decision to attach a lien against [the plaintiff's] personal injury proceeds was an attempt to collect more money from [her] in violation of the Health Care Consumer Billing Disclosure Protection Act ("the Balanced Billing Act" or "BBA")." *Id.* The center moved for summary judgment, which the district court granted. *Id.* at *1—*2.

The Second Circuit reversed. The appellate court explained that, though the medical center "had both a statutory right under the medical lien statute and express consent from [the plaintiff] to seek payment for [the plaintiff's] medical treatment through the attachment of a medical lien," the plaintiff "did not and could not consent to being billed for an amount in excess of her contracted rate." *Id.* at *4. The circuit court stated:

> The BBA prohibits a medical care provider from directly or indirectly billing an insured for any amount in excess of the contracted rate under its member provider agreement. Both this court and the Louisiana Supreme Court have held that the BBA provides a private right of action for any violations of the statute. The medical lien statute authorizes health care providers to recover reasonable charges or fees from third party tortfeasors. The question before us is how, if at all, the BBA and medical lien statute correlate with one another.

Relying on Justice Guidry's dissent in *Anderson v. Ochsner Health System*, 2013–2970 (La. 07/01/14); 172 So. 3d 579, 588, the Second Circuit found that "under the BBA, the amount of a medical lien imposed on a third-party tortfeasor is limited to the healthcare provider's contracted rate with the patient's health insurance issuer." *Id.* at *4—*5. Thus, the plaintiff's medical expenses "could not exceed the contracted rate provided in her member provider agreement," and "any sum over the contracted rate can be deemed as charges [the plaintiff] never incurred." *Id.* at *5. The appellate court found:

> By alleging that the medical lien statute authorizes it to collect more than the contracted rate from the third party, [the medical center] is circuitously stating that it can avoid the strict bans imposed by the BBA by simply crafting its bill as a medical lien instead of as a claim filed with the medical insurance company. Not only does this court reject this notion but we also find this practice to be disingenuous and somewhat deplorable. If such methods were permissible, there would be no need for the BBA. We find that [the medical center], by attaching a medical lien for an amount greater than the contracted rate, attempted to collect directly from the tortfeasor, and indirectly from [the plaintiff], an amount that the BBA specifically prohibits it from collecting. Neither [the plaintiff] nor the third-party tortfeasor can be forced to pay an amount that [the medical center] is not entitled to, and therefore not owed, under the BBA.

Id. The Second Circuit concluded that the center's conduct in trying to circumvent the BBA by "imposing a medical lien for an amount that exceeds the contracted rate" led to a "dispute as to the amount actually owed to" the center, thereby precluding summary judgment. *Id.*

On rehearing, the medical center argued that the Second Circuit's decision "fundamentally changes the application of the collateral source rule in tort cases." *Rabun v. St. Francis Med. Ctr., Inc.*, 50,849 (La. App. 2 Cir. 11/23/16); --- So. 3d ----; 2016 WL 6892840, at * 1 (per curiam). In rejecting the argument, the appellate court explained:

> Pursuant to the collateral source rule, an injured plaintiff's tort recovery may not be reduced as a result of receiving compensation from independent sources. However, the opinion of this Court focuses strictly on what a medical provider, and not a plaintiff, can recover from a tortfeasor. Notably, it does not in any manner whatsoever address the collateral source rule. Notwithstanding, in an

effort to clarify our original opinion, we hereby amend part of the discussion as follows:

> Considering the BBA prohibits a contracted healthcare provider from billing, or attempting to bill, a patient in excess of the contracted reimbursement rate, [the plaintiff's] obligation to [the medical center] cannot exceed the contracted rate set forth in the member provider agreement. As such, [the medical center] is precluded from recouping or attempting to recoup from [the plaintiff] any amount that exceeds the contracted rate. Consequently, [the medical center] cannot, in an astute effort to procure what the BBA precisely bans it from procuring, force the third party tortfeasor to pay [the medical center] the entire amount of [the plaintiff's] unreduced medical bill. It would seem plausible and appropriate that [the plaintiff] reap the benefits of, and not penalized for, having medical insurance. [The plaintiff], not [the medical center], should recover any residual sums remaining after the contracted rate has been deducted from the unreduced medical bill. Accordingly, [the medical center's] right to attach a medical lien to [the plaintiff's] tort claim in which [the plaintiff] seeks to recover damages from a tortfeasor, is limited to the contracted rate.

Furthermore, the line which reads "Neither [the plaintiff] nor the third-party tortfeasor can be forced to pay an amount that [the medical center] is not entitled to, and therefore not owed, under the BBA", is amended to "Neither [the plaintiff] nor the third-party tortfeasor can be forced to pay [the medical center] an amount that [the medical center] is not entitled to under the BBA."

Id. In all other respects, the original opinion remained "in full force and effect." *Id.*

"Free" Medical Services Provided to Doctor at Her Clinic: In *Johnson v. Neill Corp.*, 2015-0430 (La. App. 1 Cir. 12/23/15); 2015 WL 9464625, at *10, *writ denied*, 2016-0137 (La. 3/14/16); 189 So. 3d 1068, *and writ denied*, 2016-0147 (La. 3/14/16); 189 So. 3d 1070 (unpublished), the plaintiff, a doctor at a local clinic, filed suit against a salon and its employee for a negligently performed massage. *Id.* at *1, *10. The trial court awarded plaintiff, among other amounts, $107,811.00 in past medical expenses. *Id.* at *8. On appeal, the defendants argued that the trial court erred because this award "included expenses for medical services that were purportedly rendered to her free of charge as a professional courtesy." *Id.* at *8.

The First Circuit rejected the defendants' argument. The appellate court analyzed the issue using the two policies discussed in *Bozeman*, but the circuit court placed particular emphasis on the first policy:

> In *Cutsinger*, rendered subsequent to *Bozeman* and *Bellard*, the Louisiana Supreme Court stated that "the **primary policy reason** for the application of the collateral source rule is tort deterrence" and that "[w]hile it is important to consider whether plaintiff paid for the collateral source or suffered some diminution in her patrimony due to the availability of the benefit to determine whether a double recovery would result from application of the rule, this consideration alone is not the determinative factor in deciding whether the collateral source rule applies." *Cutsinger v. Redfern*, 2008–2607 (La. 5/22/09), 12 So. 3d 945, 952, 954. (Emphasis added). Thus, *Cutsinger* reflects that a careful analysis of the facts of each particular case in light of each *Bozeman* factor individually, with emphasis placed on the first factor, *i.e.*, whether application of the collateral source rule to the facts of a particular case will further the major policy goal of tort deterrence, is the appropriate approach. *See Cutsinger v. Redfern*, 12 So.3d at 952, 954–955.

Id. at *10 (bold added by *Johnson*, underline added here).

Applying these factors, the *Johnson* court found no merit to the defendants' arguments. The first factor weighed strongly in favor of the plaintiff:

> Clearly, the first *Bozeman* factor is satisfied, in that application of the collateral source rule herein will further the major policy of tort deterrence. Here, [the defendants] are seeking a credit for the professional courtesy discounts provided to or obtained by [the plaintiff], with no contribution by the defendant tortfeasors for such benefits she obtained. Thus, absent the application of the collateral source rule herein, the major policy goal of tort deterrence would be rendered meaningless.

Id. at *10. As to the second consideration, the First Circuit determined that the plaintiff and other doctors at the clinic provide gratuitous medical services for other doctors and their families, and, in return, the plaintiff had received the same gratuitous services. *Id.* Thus, the First Circuit found this exchange of services between doctors in the clinic and the Baton Rouge area is a diminution in the plaintiff's patrimony such that the defendants are not entitled to take advantage of any discounts she received. *Id.* at *10—11. The First Circuit also noted that the

discounts were provided by virtue of her status as a doctor, and she suffered a diminution in her patrimony in order to become one (e.g., by paying for medical school). *Id.* at *10 n. 9.

However, the First Circuit found that, even if there had been no diminution of patrimony, under *Cutsinger,* this consideration alone was not dispositive. *Id.* at *11. The appellate court concluded:

> The question then becomes, "who should gain the benefit of the collateral source, the injured victim or the tortfeasor?" Given the Supreme Court's instruction that the primary policy reason for the application of the collateral source rule is tort deterrence, *Cutsinger v. Redfern,* 12 So. 3d at 952, the plaintiff/injured victim, and not the tortfeasor defendant, should benefit from the collateral source where it was obtained neither by the tortfeasor's procuration nor by a diminution of the injured victim's patrimony. Thus, allowing a credit against Dr. Jones's recovery herein would directly benefit Mr. Ashton and his employer by allowing them to receive an undeserved windfall, thereby undermining the deterrent effect of tort law. *Cf. Cutsinger v. Redfern,* 12 So. 3d at 952 & *Bellard v. American Central Insurance Co.,* 980 So. 2d at 670 n. 6. Also, under the facts herein, where medical services were provided by private benefactors at a free or reduced rate for Dr. Jones's benefit, allowing Dr. Jones to recover these written-off sums from defendants would not be "unconscionable," as opposed to the situation in *Bozeman* where the taxpayers paid for the benefit of free medical care under the Medicaid program. *Bozeman v. State*, 879 So. 2d at 705. Thus, applying this rationale to the particular facts herein, we find the trial court correctly applied the collateral source rule, and that the defendants were not entitled to a reduction of the amounts actually owed by them, for any such discounts or reductions provided to Dr. Jones in the form of professional courtesy discounts.

Id.

"Write-off" from Plaintiff's Personal Negotiation with Healthcare Provider: In *Lockett v. UV Insurance Risk Retention Group, Inc.*, 15-166 (La. App. 5 Cir. 11/19/15); 180 So. 3d 557, 568, the Louisiana Fifth Circuit examined whether the collateral source rule applied to medical expenses that were "written-off" by virtue of the plaintiff's personal negotiation with the healthcare provider.

The plaintiff was injured in an automobile accident and had significant medical expenses as a result of the accident. *Id.* at 560—62. Instead of filing an insurance claim, the plaintiff

negotiated with the health care provider directly. *Id.* at 569. The health care provider agreed to accept a reduced amount for the medical expenses because the plaintiff was going to personally pay the reduced rate immediately. *Id.*

In finding that the collateral source rule applied, the Fifth Circuit distinguished this case from *Hoffman* because the reduction of the medical expenses was done through the plaintiff's personal efforts and funds, and the reduction was totally independent of the defendants' procuration or contribution. *Id.* at 571. The Fifth Circuit also found that, under *Bozeman*, the plaintiff's patrimony was diminished when she paid the reduced rate out of her own funds. *Id.* at 572. Accordingly, the appellate court held that the collateral source rule applied and that the plaintiff was entitled to the benefit of her bargain; thus, she was entitled to recover the full cost of her medical expenses. *Id.*

Medicaid/Medicare: In *Johnson v. CLD, Inc.*, 50-94 (La. App. 2 Cir. 9/30/15); 179 So. 3d 695, 706, the Second Circuit found (1) that the plaintiff was entitled to recover the amount actually paid by Medicaid; (2) that, pursuant to *Bozeman*, the plaintiff could not recover the amount "contractually adjusted" or "written off" by the healthcare provider because of Medicaid, and (3) that the plaintiff's "recovery would not be reduced by the amount of medical expenses paid by Medicare or private insurance benefits." The Second Circuit was unable to determine what amounts the plaintiff was entitled to, and the parties did not address the issue further. *Id.* The appellate court recognized that the Patient's Compensation Fund introduced a Medicaid lien letter which "demonstrated the existence of a lien, but it did not answer the issue to be resolved under *Bozeman*." *Id.* The Second Circuit "determined that the lower court would need to make a determination of what portion of the medical bills is not recoverable under *Bozeman*." *Id.*

Uninsured motorist/medical payments: In *Howard v. United Services Auto Association*, 2014-1429 (La. App. 1 Cir. 7/22/15); 180 So. 3d 384, *writ denied*, 2015-1595 (La. 10/30/15); 179 So. 3d 615, the First Circuit examined whether the defendant was entitled to a credit for the amounts received by the plaintiff from her insurer, State Farm. Before trial, State Farm paid the plaintiff $5,000 in medical payment benefits and $10,000 in UM policy limits for injuries resulting from an automobile accident. *Id.* at 389, 399. The defendant motorist was insured with a policy with USAA with a limit of $25,000. *Id.* at 390.

Prior to trial the defendants filed a motion asserting that they should be entitled to a $15,000 credit for any award above the $25,000 policy limit. *Id.* Defendants attached a letter to their motion from State Farm stating that State Farm had no intention of pursuing recovery of the amounts paid to the plaintiff. *Id.* The trial court applied the $15,000 credit to the award reducing the judgment from $42,000 to $27,000. *Id.*

The First Circuit held:

> For the reasons that follow, we find the district court erred in granting the $5,000.00 credit for the medical payments benefits, and reverse that portion of the judgment. Further, although we find the district court did not err in awarding the $10,000.00 credit against the damages awarded plaintiffs by the jury's verdict, we find the district court failed to specify that the credit awarded applied only to any judgment awarded *in excess of USAA's policy limits.* In order to recover from a UM insurer, there must first be a determination that the tortfeasor was liable for damages in an amount in excess of the tortfeasor's liability insurance policy. *Kelley v. General Ins. Co. of America*, 2014–0180 (La. App. 1 Cir. 12/23/14), 168 So.3d 528 (Pettigrew, J. concurring); *see also, Rizer v. American Sur. & Fid. Ins. Co.*, 95–1200 (La. 3/8/96), 669 So. 2d 387, 390. Thus, in that regard, the November 14, 2013 judgment is amended.

Id. at 400 (emphasis in original). The First Circuit then examined the two amounts separately, as each was paid to the plaintiff for a different purpose. *Id.*

First, the circuit court found that the trial court did not err with regards to awarding the $10,000 credit. *Id.* The appellate court followed the reasoning in *Fertitta v. Allstate Insurance*

Co., 462 So. 2d 159 (La. 1986). *Id.* *Fertitta* was directly on point and addressed the issue of "whether the tort victim's judgment against the tortfeasor for the full amount of the victim's damages should be reduced by the amount of the victim's pretrial settlement with his UM carrier, when the latter, as part of the settlement, has waived any right of reimbursement or subrogation." *Id.* The collateral source rule does not override the principles of solidarity in the Civil Code. *Fertitta*, 462 So. 2d at 162. The court in *Fertitta* held that such a credit was "due to any award *in excess of* the tortfeasor's policy limits." *Id.* (citing *Fertitta*, 462 So. 2d at 162 (emphasis by *Howard* court)). The First Circuit concluded:

> As in *Fertitta*, in this matter, the tortfeasor's liability coverage (USAA's policy limits of $25,000.00) is less than the amount of damages awarded to plaintiffs. Thus, both, State Farm and [the tortfeasor] (and her insurer, USAA) were legally bound by separate provisions of law to repair plaintiffs' damages in the amount that those damages exceeded the limits of [the tortfeasor's] liability policy, despite the independent sources of liability. When the liability is solidary, the creditor (plaintiffs) cannot collect more than the full amount of the debt for the single or combined payments of the debtors, such that solidarity is not inconsistent with the purpose of providing full recovery to the tort victim. *Id.* at p. 163. Accordingly, the district court did not err in awarding $10,000.00 as a credit.

Id. at 400—01.

Second, the appellate court found that granting a credit for the $5,000 medical payment would be a violation of the collateral source rule. *Id.* at 401. The First Circuit stated:

> Even the *Fertitta* court noted that in the case of medical payments, because only the contract (and not the law) imposes the obligation on the insurer to repair some of the damages caused by the tortfeasor, there arguably is no solidary liability. *Fertitta*, 462 So.2d at 164 n. 7. The insured must specifically request that coverage, and medical payment and collision insurers are contractually liable for any medical expenses or collision damages, notwithstanding that those expenses and damages were caused by a tortfeasor and not the insured.

Id. at 401.

Workers' Compensation: In *Madrid v. AEP River Operations, LLC*, 2014-0044 (La. App. 4 Cir. 10/15/14); 151 So. 3d 897, 900, *writ granted*, 2014-2384 (La. 2/27/15); 159 So. 3d

1062, the Fourth Circuit reviewed whether the trial court erred by not applying the collateral source rule when awarding medical expenses. The plaintiff incurred $65,100 in medical expenses from a work place accident. *Id.* at 901. Louisiana Workers' Compensation Corporation (LWCC) paid $27,159.25 of the medical expenses directly to the medical care providers. *Id.* The trial court awarded only the amount paid by LWCC, rather than the full amount of the plaintiff's medical expenses. *Id.*

The Fourth Circuit awarded the plaintiff past medicals. *Id.* at 902. The circuit court stated that the defendant essentially profited from the medical benefit personal to the plaintiff. *Id.* at 901. The appellate court found that *Bozeman* "reiterated the longstanding reasoning that the rule promotes tort deterrence[,] . . . was limited [to Medicaid write-offs], and in no way . . . diminish[ed] the collateral source rule's application under other circumstances." *Id.*

The appellate court also cited *Davis v. Odeco*, 18 F.3d 1237 (5th Cir. 1994), where the plaintiff brought claims under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 905(B). The Fourth Circuit stated:

> The *Davis* Court, explained that even when third parties pay the compensation for plaintiffs' injuries, such payment should not have the effect of giving a windfall to tortfeasors. Permitting tortfeasors to set-off compensation available to plaintiffs from collateral sources would allow them to escape bearing the costs of their own conduct. Additionally, some courts emphasize that the collateral source rule prevents the deterrent effect of tort judgments from being undermined. Sources of compensation that have no connection to the tortfeasor are inevitably collateral.

Id. at 901—02 (footnotes omitted). The Fourth Circuit found the collateral source rule applied and awarded the plaintiff past medical expenses in the amount of $37,940.75. *Id*. at 902.

Tortfeasor's Insurance: In *Moore v. Stewart*, 47,206 (La. App. 2 Cir. 6/27/12); 94 So. 3d 1018, 1025, the Second Circuit determined the plaintiff could not recover medical expenses that were covered by the tortfeasor's insurance. Plaintiff was punched several times by her husband during a domestic dispute. *Id*. at 1021. Her husband then took her to the doctor, and his

insurance covered her medical expenses. *Id.* at 1026. The plaintiff filed suit to recover the medical expenses as well as other damages related to the altercation. *Id*. at 1020. In examining whether the plaintiff could recover the medical expenses, the Second Circuit cited *Bozeman* and determined that the plaintiff could not recover the damages because a payment made by or on behalf of a tortfeasor is credited against his liability. *Id.* at 1026. The plaintiff may be able to recover expenses not covered, such as deductibles and co-pays, but the burden of proof is on the plaintiff. *Id.*

Percentage of Premium Paid for Health Insurance though Spouse's Employer: In *Olivier v. City of Eunice*, 2011-1054 (La. App. 3 Cir. 6/6/12); 92 So. 3d 630, 635, the plaintiff sought to recover medical expenses that corresponded to the percentage of the premium he paid for health insurance through his wife's employer. The appellate court found:

> The purpose of the WCA, the history of Sections 1205 and 1212, and the legislature's enactment of Section 1205 after jurisprudence awarded or indicated workers' compensation claimants had a right to be paid medical expenses they did not pay lead us to conclude that the legislature did not intend for workers' compensation claimants to recover medical expenses they did not pay. Recent supreme court decisions in *Cutsinger v. Redfern*, 08–2607 (La. 5/22/09), 12 So. 3d 945, and *Bellard v. American Central Insurance Co.*, 07–1335, 07–1399 (La. 4/18/08), 980 So. 2d 654, reinforce that conclusion.

Id. at 638. The Third Circuit started, as in those cases, by examining whether the plaintiff's insurer, Blue Cross, and his employer, the City, were solidary obligors. *Id.* at 638. The Court determined that they were. *Id*. at 639. The appellate court then found that, as in *Cutsinger*, *Bellard*, and *Fertitta*, "the collateral source rule does not apply to override the principles of solidarity expressly provided by our Civil Code." *Id.* at 639 (citations omitted). The *Olivier* court then examined *Cutsinger* in greater detail and found that its "logic remains applicable. . . . [The plaintiff] did not pay for health insurance to cover workers' compensation benefits owed to him by the City." *Id.* at 640. The Third Circuit concluded:

> For the following reasons, we find as the supreme court did in *Cutsinger*, *Bellard*, and *Fertitta,* that the collateral source rule does not apply here. First, the purpose of the rule, tort deterrence, is not furthered by application here, as no tort occurred. Second, Section 1212 was enacted, at least in part, to prevent the windfall recovery of medical expenses by employees when the same medical expenses were paid their employers and their health insurers. [(citation omitted)]. Third, Section 1205 provides health insurers a right of 100% reimbursement against employers and their workers' compensation insurers for medical expenses they paid for employees that are the responsibility of the employers or their workers' compensation insurers. Fourth, employees are entitled to penalties and attorney fees when employers or workers' compensation insurers do not pay covered medical expenses. Fifth, "[t]he purpose of the [WCA] was to create a compromise in which both employees and employers surrender certain advantages in exchange for others which are more valuable to both parties and society," *Deshotel v. Guichard Operating Co., Inc.*, 03–3511, p. 7 (La. 12/17/04), 916 So. 2d 72, 76–77, and to make an employer pay an employee a percentage of medical expenses paid by his health insurer when the insurer has a right to 100% reimbursement of all medical expenses it paid, resulting in the employer paying more than the employees total medical expenses, is contrary to the purpose of the WCA.

Id. Thus, the "WCJ's award of . . . 35.5% of the medical expenses already paid by Blue Cross, was error, and it [was] reversed." *Id.*

Third Party Foundation (Eye, Ear, Nose, Throat Foundation) and CoPays: In *Powell v. Chabanais Concrete Pumping, Inc.*, 11-408 (La. App. 5 Cir. 12/28/11); 82 So. 3d 548, 551, the plaintiff was injured in an accident on a jobsite and sustained injuries that would require future doctor visits. The defendant moved for partial summary judgment arguing that it should receive a credit for future medical expenses paid by the Eye, Ear, Nose, and Throat Foundation (EENT). *Id.* at 552. The defendant's argument was based on the premise that the expenses were not a collateral source because "the plaintiff did not contribute to the plan that paid the expenses." *Id.* at 552. The trial court denied the motion. *Id.* The defendant re-asserted the argument on appeal and relied on *Bozeman*. *Id.* at 560.

In rejecting this argument, the Fifth Circuit explained how, in *Bozeman*, the plaintiff sought to recover amounts in excess of what Medicaid actually paid, and the *Bozeman* court

determined that the plaintiff was only entitled to the amounts Medicaid actually paid. *Id.* at 560—61. Here, the plaintiff only sought the amounts EENT would actually pay for his medical services. *Id.* at 561. Thus, the defendant's reliance on *Bozeman* was misplaced.

The defendant also argued on appeal that the EENT was not a collateral source because the plaintiff will not and did not suffer a diminution of his patrimony in order to receive the benefit. *Id.* The appellate court found that the $20 copay the plaintiff would be required to pay at each visit is a diminution of his patrimony. *Id.* The Fifth Circuit also noted that, even if the medical services cost the plaintiff nothing, the defendant "cannot profit thereby." *Id.* (citing *Spizer v. Dixie Brewing Co.*, 210 So. 2d 528, 533 (La. App. 4 Cir. 1968)). Thus, the defendant's assignment of error was without merit. *Id.*

III. Insurance Bad Faith

A. General Principles

In *Smith v. Audubon Ins. Co.*, 95-2057 (La. 9/5/96); 679 So. 2d 372, the Louisiana Supreme Court provided essentials for understanding an insurer's duty of good faith with respect to settling claims. The Court stated:

> In the absence of bad faith, a liability insurer generally is free to settle or to litigate at its own discretion, without liability to its insured for a judgment in excess of the policy limits. William Shelby McKenzie & H. Alston Johnson, III, 15 *Louisiana Civil Law Treatise–Insurance Law and Practice* § 218 (1986). On the other hand, a liability insurer is the representative of the interests of its insured, and the insurer, when handling claims, must carefully consider not only its own self- interest, but also its insured's interest so as to protect the insured from exposure to excess liability. *Holtzclaw v. Falco, Inc.*, 355 So. 2d 1279 (La. 1978) (on rehearing). Thus, a liability insurer owes its insured the duty to act in good faith and to deal fairly in handling claims. *Id.*

Id. at 377. Though the Supreme Court "recognize[ed] in *Roberie v. Southern Farm Bureau Casualty [Insurance] Co.*, 250 La. 105, 194 So.2d 713 (1967) the responsibility of a liability insurer to deal in good faith with a claim against its insured," the Supreme Court had "never held

a liability insurer liable for an excess judgment rendered against the insured." *Id.* "Nevertheless, intermediate state courts and federal courts have held liability insurers liable for an excess judgment when the insurer failed to deal in good faith with a claim against its insured." *Id.* (collecting cases). The Supreme Court then stated:

> Thus, the determination of whether the insurer acted in bad faith turns on the facts and circumstances of each case. Of course, an insurer is not obliged to compromise litigation just because the claimant offers to settle a claim for serious injuries within the policy limits, and its failure to do so is not by itself proof of bad faith. The determination of good or bad faith in an insurer's deciding to proceed to trial involves the weighing of such factors, among others, as the probability of the insured's liability, the extent of the damages incurred by the claimant, the amount of the policy limits, the adequacy of the insurer's investigation, and the openness of communications between the insurer and the insured. Nevertheless, when an insurer has made a thorough investigation and the evidence developed in the investigation is such that reasonable minds could differ over the liability of the insured, the insurer has the right to choose to litigate the claim, unless other factors, such as a vast difference between the policy limits and the insured's total exposure, dictate a decision to settle the claim.

Id. at 377 (footnote omitted).

B. Overview of the *Kelly* Case

The most recent case by the Louisiana Supreme Court concerning bad faith by an insurer is *Kelly v. State Farm Fire & Casualty Co.*, 2014-1921 (La. 5/5/15); 169 So. 3d 328. In *Kelly*, the Court addressed two questions certified to it by the federal Fifth Circuit:

> (1) Can an insurer be found liable for a bad-faith failure-to-settle claim under Section 22:1973(A) when the insurer never received a firm settlement offer?
>
> (2) Can an insurer be found liable under Section 22:1973(B)(1) for misrepresenting or failing to disclose facts that are not related to the insurance policy's coverage?

Id. at 330 (citing *Kelly v. State Farm & Cas. Co.*, 582 F. App'x 290, 296 (5th Cir. 2014)). The specific sections of Louisiana Revised Statutes § 22:1973 provide:

> (A) An insurer, including but not limited to a foreign line and surplus line insurer, owes to his insured a duty of good faith and fair dealing. The insurer has an

> affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant, or both. Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach.
>
> (B) Any one of the following acts, if knowingly committed or performed by an insurer, constitutes a breach of the insurer's duties imposed in Subsection A of this Section:
>
> > (1) Misrepresenting pertinent facts or insurance policy provisions relating to any coverages at issue.

La. Rev. Stat. § 22:1973. In short, the Supreme Court answered these questions as follows:

> 1) 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 claim, because the insurer's duties to the insured can be triggered by information other than the mere fact that a third party has made a settlement offer; 2) An insurer can be found liable under La. R.S. 22:1973(B)(1) for misrepresenting or failing to disclose facts that are not related to the insurance policy's coverage because the statute prohibits the misrepresentation of "pertinent facts," without restriction to facts "relating to any coverages."

Kelly, 169 So. 3d at 330.

C. *Kelly*'s Facts and Procedural Background

Kelly was an automobile accident case. *Id.* at 331. Danny Kelly and Henry Thomas were driving in opposite directions. *Id.* Thomas turned left and ran into Kelly. *Id.* Kelly and a witness told police that Thomas refused to yield, but Thomas denied liability. *Id.* Kelly was brought to the hospital by ambulance, treated for a broken femur, remained at the hospital for about six days, and incurred $26,803.17 in costs for medical care. *Id.*

Thomas had liability insurance with State Farm. *Id.* In January 2006, Kelly's attorney sent a letter to State Farm concerning Kelly's injury. *Id.* "The letter included copies of Kelly's hospital records" and stated:

> Please find enclosed a copy of Danny Kelly's Medical Summary with attached medical records/reports and bills concerning his hospital treatment for the above referenced incident involving your insured. I will recommend release of State

> Farm Insurance Company and your insured, Henry Thomas, Jr., for payment of your policy limits. . . . Please give me a call in the next ten (10) days to discuss this matter.

Id. "State Farm did not respond to the letter." *Id.* Later, in March 2006, State Farm wrote a letter to Kelly's attorney offering to settle for the policy limit. *Id.* The offer was rejected, and the matter proceeded to trial. *Id.*

At trial, Thomas was found liable and cast in judgment for $176,464.07. *Id.* After the judgment, Thomas settled with Kelly and assigned his right to pursue a bad faith claim against State Farm to Kelly in exchange for his promise not to enforce the judgment against him. *Id.*

Kelly then filed suit alleging State Farm was liable for bad faith practices under Louisiana law. *Id.* The district court recognized two actionable claims: (1) failure to notify the insured of the January 2006 letter, and (2) failure to accept the victim's January 2006 settlement offer. *Id.* (citing *Kelly*, 582 F. App'x at 293).

The district court granted summary judgment in favor of State Farm on both claims, finding (1) the January 2006 letter did not constitute a settlement offer and State Farm did not have a duty to inform Thomas when the letter was received, and (2) "State Farm could be liable for bad faith failure to settle only if it failed to accept an actual offer and acted in bad faith." *Id.* at 331—32. Kelly appealed the dismissal of his claims. *Id.* at 332.

On appeal, the United States Fifth Circuit affirmed in part and reversed in part. *Id.* (citing *Kelly*, 559 F. App'x at 316). "The [appellate] court affirmed dismissal of what [it] would later identify as the second claim (i.e., the duty to settle claim), reasoning that '[b]ecause Kelly's purported settlement letter and medical receipts did not constitute "a satisfactory proof of loss from the insured," Kelly cannot maintain a claim under § 22:1892(A)(1) as a matter of law.' " *Id.* (citing *Kelly*, 559 F. App'x at 320). But the Fifth Circuit reversed dismissal of the first claim

(*i.e.*, the duty to inform claim), stating in part:

> In short, State Farm sent a single cursory communication to Thomas, and it cannot be said as a matter of law that this letter communicated the pertinent facts necessary for Thomas to determine what was in his best interest. Therefore, State Farm was not entitled to judgment as a matter of law on Kelly's claim under La. R.S. § 22:1973(B)(1).

Id. (citing *Kelly*, 559 F. App'x at 322).

The parties then filed petitions for rehearing. *Id.* The Fifth Circuit granted these petitions, "withdrew its earlier opinion[,] and issued another opinion certifying the two earlier-quoted" questions of Louisiana law. *Id.* (citing *Kelly*, 582 F. App'x at 294).

In the second opinion, the Fifth Circuit "divided its review of the pertinent jurisprudence into two categories, focusing only on 'Thomas's claims [against State Farm] under Section 22:1973(A) and (B)(1)." *Id.* (quoting *Kelly*, 559 F. App'x at 322). Under the first category, which focused on interpreting Section 22:1973(A), Kelly himself would not have a right to sue the insurer for a generalized breach of its duty of good faith and fair dealing because Kelly is a third-party. *Id.* at 332—33 (citing *Theriot v. Midland Risks Ins. Co.*, 95-2895 (La. 5/20/97); 694 So. 2d 184, 188-93). However, because Kelly was pursuing the claims assigned to him by Thomas (the insured), Kelly had a cause of action that was not barred by *Theriot*.

The next issue was whether, even if Kelly had a right of action, an insurer could be liable for a bad-faith failure-to-settle claim without receiving a firm settlement offer from a claimant. *Id.* at 333. On the one hand, *Commercial Union Insurance Co. v. Mission Insurance Co.*, 835 F.2d 587, 588, & n.2 (5th Cir. 1988) required a firm settlement offer, but, on the other hand, "*Commercial Union*'s holding [was] seriously undermined by the subsequent enactment of Section 22:1973(A), which provides that '[t]he insurer has an *affirmative duty* . . . to settle claims with the insurer or the claimant, or both." *Id.* (quoting *Kelly*, 582 F. App'x at 294—95).

The appeals court further explained the need to certify the first question:

> Section 22:1973(A)'s imposition of an affirmative duty to make a reasonable effort to settle claims suggests that insurers must do more than simply rest on their laurels and wait for claimants to submit firm settlement offers. Particularly given Louisiana's civilian methodology, which treats jurisprudence as secondary to statutes, this statutory enactment casts serious doubt on our prior jurisprudence on this issue.
>
> Again, the Supreme Court of Louisiana and the Louisiana intermediate appellate courts have never held that a firm settlement offer is required for a bad-faith failure-to-settle claim. But Kelly has not directed us to any Louisiana cases that find an insurer liable for bad-faith failure-to-settle in the absence of a firm settlement offer. The resolution of this issue is thus unclear under both Louisiana law and our own precedent. Moreover, this issue is determinative. Kelly's petition for rehearing does not claim that he made a binding settlement offer, and therefore Kelly will lose if he must show that he made such an offer.

Id. (citing *Kelly*, 582 F. App'x at 294—95).

Concerning the second category (La. Rev. Stat. § 22:1973(B)), the Fifth Circuit found that the jurisprudence in Louisiana state appellate courts was conflicting on the issue of whether a misrepresentation must relate to coverage under Section 22:1973(B). *Id.* at 333—34 (collecting cases). Indeed, the United States Fifth Circuit's own jurisprudence conflicted on the issue. In *Versai Management Corp. v. Clarendon America Insurance Co.*, 597 F. 3d 729 (5th Cir. 2010), the court "suggested in dicta that Section 22:1973(B)(1) only applies to misrepresentation about coverage-related facts." *Id.* at 739-40 (quoting *Versai*, 596 F.3d at 730—40). However, the court also cited *McGee v. Omni Insurance Co.*, 2002-1012 (La. App. 3 Cir. 3/5/03); 840 So. 2d 1248, 1256, which held the opposite of the suggested dicta. The Fifth Circuit summarized the reasons to certify the second question as follows:

> [I]f we apply *McGee*, Kelly should almost certainly win. As in *McGee*, Kelly's primary complaint under Section 22:1793(B)(1) is that State Farm failed to communicate the status of Kelly's claim and settlement negotiations to Thomas. *Versai* therefore cuts in two opposing directions in this case; *Versai* 's reliance on *McGee* indicates that Kelly should win, but *Versai* 's dicta suggests that Kelly should lose.

Id. at 334.

D. The Louisiana Supreme Court's Analysis in *Kelly*

1. The First Certified Question: Can an insurer be liable for a bad-faith failure to settle claim under La. Rev. Stat. 22:1973(A) when the insurer never received a firm settlement offer?

The first certified question required an interpretation of La. Rev. Stat. § 22:1973(A). *Id.* at 335. Again, this section provides:

> (A) An 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.

Id. The Louisiana Supreme Court explained that this first certified question was "twofold" *Id.* The first clause – "[c]an an insurer be found liable for a bad-faith failure-to-settle claim under" Section 22:1973(A)? – must be decided before proceeding to the second clause – "whether a firm settlement offer is required." *Id.*

1. Can an insurer be liable for a bad-faith failure-to-settle claim?

The Supreme Court began its analysis of the first clause by explaining that "[t]hird parties have no cause of action under La. R.S. 22:1973(A). Subsection A of La. R.S. 22:1973 describes an insurer's general duties, but subsection B contains an exclusive list of actionable breaches of those duties for which third-party claimants can recover." *Id.* (citing *Theriot*, 694 So. 2d at 193). The Supreme Court also observed that the relationship between an insured and insurer involves duties arising from the contract between them, and this includes the implied covenant of good faith and fair dealing. *Id.* (citing *Theriot*, 694 So. 2d at 193). Conversely, "[t]he relationship between the insurer and third-party claimant is neither fiduciary nor contractual; it is fundamentally adversarial." *Id.* (quoting *Theriot*, 694 So. 2d at 193). Thus, in *Kelly*, the

Supreme Court "approach[ed] La. R.S. 22:1973(A) from the proposition that the insurer undertakes in an insurance contract certain fiduciary duties toward the insured." *Id.*

The Supreme Court then asserted that "[t]he plain language of La. R.S. 22:1973 is favorable to finding a cause of action for an insured." *Id.* at 336. Again, Section 22:1973(A) concludes, after listing duties owed by an insurer, with the following: "Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach." *Kelly*, 169 So. 3d at 336. The "shall" is mandatory and "indicate[s] that an insurer is liable for a breach of the duties described in La. R.S. 22:1973(A)[.]" *Id.*

The Supreme Court explained how "this [led] [the Court] . . . to the question of whether there is sufficient justification to find an *insured* has a cause of action under *La. R.S. 22:1973(A),* when [the Court] ruled in *Theriot* that *a third-party claimant* has no such cause of action - third parties can only recover under *La. R.S. 22:1973(B).*" *Id.* (emphasis added) (citing *Theriot,* 95-2895 at 7). The answer was suggested in *Theriot*, when the Court stated that "The first sentence of Subsection A of the statute recognizes the jurisprudentially established duty of good faith and fair dealing owed to the insured, which is an outgrowth of the contractual and fiduciary relationship between the insured and the insurer." *Id.* (quoting *Theriot*, 694 So. 2d at 187). Or, as the federal Fifth Circuit stated in *Stanley v. Trinchard,* " '[i]nasmuch as it is not the statute that *creates* the insured's cause of action against the insurer, the basis 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:[1973](B).' " *Id.* (quoting *Stanley v. Trinchard,* 500 F.3d 411, 427 (5th Cir.2007) (emphasis in *Stanley*)). The Supreme Court concluded that "the legislature essentially codified within La. R.S. 22:1973(A) a jurisprudentially-recognized cause

of action in favor of insureds for an insurer's bad faith failure to settle." *Id.* By enacting Section 22:1973(A), the Legislature intended its remedial measures to add rights, not restrict them.

The high court also recognized the "long lineage" of cases recognizing "a cause of action for insureds to recover from a judgment in excess of policy limits." *Id.* at 337 (citations omitted). The Court concluded:

> This long lineage of jurisprudence and the remedial intent of La. R.S. 22:1973(A) have important consequences for the availability of a cause of action for insureds under La. R.S. 22:1973(A). Because legislation is a primary source of law and *jurisprudence constante* is a secondary source of law, it follows that the legislature would not elevate the rights of claimants by establishing a cause of action enshrined by a statute, while leaving insureds with a cause of action tethered only to jurisprudence. The relationship between an insurer and a third-party claimant, we have observed, is adversarial. In contrast, the relationship between an insurer and the insured is fundamentally different because "a liability insurer is the representative of the interests of its insured and the insurer, when handling claims, must carefully consider not only its own self interest, but also its insured's interest so as to protect the insured from exposure to excess liability." Thus, to grant third-party claimants (who have an adversarial relationship to the insurer) a statutorily-recognized cause of action for an insurer's bad faith, while leaving insureds (whom the insurer is bound to protect) only a jurisprudentially recognized cause of action, would be an absurd and inequitable result. Our civilian mandate prohibits us from interpreting a statute in a manner that would lead to such absurd results. *See* La. R.S. 1:4 ("When the wording of a Section is clear and free of ambiguity, the letter of it shall not be disregarded under the pretext of pursuing its spirit.").
>
> Therefore, in light of the jurisprudence and the remedial intent of La. R.S. 22:1973(A), we return to the first clause of the certified question, which asks: Can an insurer be found liable for a bad-faith failure-to-settle claim under subsection A of La. R.S. 22:1973? Having determined that the plain language supports the existence of a cause of action in favor of the insured under La. R.S. 22:1973(A), we answer this question affirmatively. Based on our review of the jurisprudence and the remedial intent of La. R.S. 22:1973, to our federal colleagues' observation in *Stanley*, we add that La. R.S. 22:1973(A) represents a legislative recognition of a cause of action found earlier only in the jurisprudence.

Id. at 337–38 (citations and footnotes omitted).

2. Is a firm settlement offer required?

In looking at the second clause of the first certified question, the Court began by

examining the plain language of the statute and determined that, under Section 22:1973(A), the insurer has an "affirmative duty to make a reasonable effort to settle claims with the insured or the claimant, or both." *Id.* at 340. After considering the language of the statute and rejecting State Farm's interpretation of *Smith v. Audubon Ins. Co.*, 95–2057 (La.9/5/96), 679 So.2d 372, on this issue, the Supreme Court narrowed the issue: whether an insurer's affirmative duty to make a reasonable effort to settle claims is triggered only by receipt of a firm settlement offer. *Id.*

In answering this question, the Supreme Court explained that the requirement of a firm settlement offer is not listed anywhere in the statute and that imposing the requirement of a firm settlement offer would essentially be adding words to the statute. *Id.* The high court also found practical reasons for not requiring a firm offer as a condition for bad faith, explaining:

> The insured has no control over whether a firm offer will be submitted. For that matter, neither does the insurer. Yet, the insurer has undertaken the obligation to protect the insured. "[I]n 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." [(citations omitted)] Therefore, we see no practical reason why the insurer's obligation to act in good faith should be made subject to the tenuous possibility that an insurer will receive a firm settlement offer. Instead, the insurer's obligation to act in good faith is triggered by knowledge of the particular situation, which knowledge "[t]he insurer has an affirmative duty" to gather during the claims process. *See* La. R.S. 22:1973(A). *See also Smith*, 95–2057 at 9–10, 679 So. 2d at 377 (finding that an insurer has a duty to conduct "a thorough investigation" and to consider "the evidence developed in the investigation" when determining whether to litigate or settle).

Id. at 341.

The Supreme Court also rejected State Farm's argument that a bright-line test was required. *Id.* The Supreme Court stated that *Smith*'s "five non-exclusive factors . . . articulated as part of a case-by-case determination should adequately address State Farm's desire for clearly defined ways to measure whether an insurer has made 'a reasonable effort to settle claims' (La.

R.S. 22:1973(A)) and to thereby protect the insured from excess liability." *Id.* (citing *Smith*, 679 So.2d at 377).

After addressing both of the first questions' separate clauses, the high court held that "an insurer can be found liable for a bad-faith failure-to-settle claim under La. R.S. 22:1973(A), notwithstanding that the insurer never received a firm settlement offer." *Id.* at 341.

2. Second Certified Question: Liability under La. Rev. Stat. § 22:1973(B) for Misrepresenting or Failing to Disclose Facts That Are Not Related to the Insurance Policy's Coverage

"The second certified question ask[ed] [the Court] to decide whether an insurer can be found liable under [Section] 22:1973(B)(1) for misrepresenting or failing to disclose facts that are not related to the insurance policy's coverage." *Id.* The relevant language of Section 22:1973(B) prohibits an insurer from "[m]isrepresenting pertinent facts or insurance policy provisions relating to any coverages at issue." *Id.* at 341—42.

The United States Fifth Circuit did not answer this question because there was no ruling from the Louisiana Supreme Court and because the jurisprudence from the Louisiana appellate courts gave differing answers. *Id.* at 342. The Supreme Court summarized the conflict as follows:

> [T]wo appellate courts found that an actionable misrepresentation is limited to a misrepresentation that "relate[s] to a coverage issue" and "[a] misrepresentation relating to a coverage issue would involve facts about the policy itself, such as the amount of coverage, lapse or expiration of the policy, or exclusions from coverage." [*Talton v. USAA Cas. Ins. Co*., 06-1513 (La. App. 4 Cir. 3/19/08); 981 So. 2d 696, 710 (quoting *Strong v. Farm Bureau Ins. Co*., 32,414 (La. App. 2 Cir. 10/29/99); 743 So. 2d 949, 953)] Two other appellate courts found that an actionable misrepresentation was not factually limited to dealing with a coverage issue. First, in *McGee*, the appellate court ruled that, in the context of evaluating the possibility of settlement, "[m]isrepresentation can occur when an insurer either makes untrue statements to an insured concerning pertinent facts or fails to divulge pertinent facts to the insured." *McGee*, 02–1012 at 11, 840 So. 2d at 1256. Then later, in [*Arvie v. Safeway Insurance of Louisiana*, 2006-1266 (La. App. 3

> Cir. 2/7/07); 951 So. 2d 1284, 1286], the appellate court cited the preceding ruling from *McGee* with approval. [*Id.*]

Id. at 342.

The Louisiana Supreme Court found that the issue in these four cases comes down to applying the word "or" in the statute. In *Talton* and *Strong*, the courts applied the word "or" so that it connected the final qualifier, *i.e.*, the words 'to any coverages at issue' with both the first phrase and the second phrase.' " *Id.* Thus, under these cases, La. Rev. Stat. § 22:1973(B)(1) reads: "Misrepresenting pertinent facts [*relating to any coverages at issue*] or insurance policy provisions relating to any coverages at issue." *Kelly*, 169 So. 3d at 342-43. Conversely, "[t]he courts in *McGee* and *Arvie* took a different interpretative approach. Tacitly, *McGee* and *Arvie* confined the phrase 'relating to any coverages at issue' to the phrase following the word 'or.' Thus, under *McGee* and *Arvie*, the first phrase would prohibit only "[m]isrepresenting pertinent facts." *Id.* at 343.

In resolving this conflict, the Court took "direct legislative guidance from La. R.S. 1:9: 'Unless it is otherwise clearly indicated by the context, whenever the term "or" is used in the Revised Statutes, it is used in the disjunctive and does not mean "and/or".' " *Id.* (quoting La. Rev. Stat. § 1:9). "While it is possible to interpret 'or' to mean 'and/or,' La. R.S. 1:9 instructs that we may only reach that conclusion if 'clearly indicated by the context.' " *Id.* Here, the Court found that the context did not clearly indicate "or" should mean anything other than "or." *Id.* "Even though the introductory word '[m]isrepresenting' applies to the phrase before and after the word 'or,' La. R.S. 22:1973(B)(1) can be given a reasonable meaning without importing words from the end of La. R.S. 22:1973(B)(1) to precede the word 'or'." *Id.* The Supreme Court noted that if the word "or" was not given a disjunctive meaning, it would render the phrase "pertinent

facts" "redundant and meaningless because misrepresentations about insurance policy provisions are addressed in the second phrase" that follows the word "or." *Id.*

> The Supreme Court ultimately concluded:
>
> **We must, therefore, apply the word "or" disjunctively, meaning that an insurer can be liable for misrepresenting either: 1) "pertinent facts," or 2) "insurance policy provisions relating to any coverages at issue." La. R.S. 22:1973(B)(1).**
>
> To the extent the intermediate appellate courts held a misrepresentation of "pertinent facts" must also "relat[e] to any coverages at issue" in order to be actionable, their holding contravenes the use of the word "or" required by La. R.S. 1:9. Accordingly, the opinions in *Talton* and *Strong* are hereby overruled.
>
> In sum, we provide the following answer to the second certified question. **An insurer can be found liable under La. R.S. 22:1973(B)(1) for misrepresenting or failing to disclose facts that are not related to the insurance policy's coverage; the statute prohibits the misrepresentation of "pertinent facts," without restriction to facts "relating to any coverages."**

Id. at 343—44 (emphasis added).

Nevertheless, the Court qualified its holding by recognizing that a "tight reigns must be kept on a cause of action for insurer settlement practices." *Id.* at 344 n. 34. *Kelly* then explained:

> For example, when responding to the suggestion that holding an insurer liable for an excess judgment was tantamount to "Monday-morning quarterbacking" and that "with the benefit of hindsight almost any settlement decision can be looked on as poor judgment," an appellate court applying pre-enactment law explained: "We are not saying that mere poor judgment is the basis of an award for bad faith failure to settle within policy limits.... the law of bad faith should be cautiously applied...." *Keith v. Comco Ins. Co.*, 574 So. 2d 1270, 1279–80 (La. App. 2 Cir. 1991), *citing Moskau v. Insurance Co. of North America,* 366 So. 2d 1004 (La. App. 1 Cir.1978). Having traced the development of a cause of action for bad faith settlement practices from the time it was a jurisprudentially-recognized cause of action to its present status as a statutorily-enshrined facet of the law, we believe it is appropriate to reiterate that La. R.S. 22:1973 should be strictly construed. [(citation omitted).] A strict application of the 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. *See Parich v. State Farm Mut. Auto. Ins. Co.*, 919 F.2d 906, 912 (5th Cir. 1990), *citing Baton v. Transamerica Ins. Co.*, 584 F.2d 907, 914 (9th Cir. 1978).

Id. (citations omitted).

E. Recent Developments after *Kelly*

Misrepresentations: In *Century Surety Co. v. Blevins*, 799 F.3d 366 (5th Cir. 2016), a company named Sohum LLC (doing business as the Regency Inn) brought a counterclaim against Century Surety Company, which had issued the Regency Inn a general-liability insurance policy. *Id.* at 369. Sohum alleged that Century violated its obligation of good faith and fair dealings by sending "a reservation of rights letter which was 'unclear and unintelligible' and failed to state any 'legitimate reason in the Policy' for denial of coverage." *Id.* The district court dismissed the Sohum's bad-faith counterclaim:

> The district court found that the Reservation of Rights Letter "confirmed [Century] was defending Sohum in the underlying lawsuit. . . . [but] it had 'no duty to defend [Sohum] against any 'suit' seeking damages for 'bodily injury' or 'property damage' to which [the Policy] does not apply." (quoting the Reservation of Rights Letter). The content of the Letter, the district court held, was not a misrepresentation in violation of § 22:1973(B)(1).

Id. at 369—370. But the Fifth Circuit found that the district court erred and reversed, explaining:

> First, the case relied upon by the district court, *Theriot v. Midland Risk Insurance Company*, 95–C–2895 (La.5/20/97); 694 So. 2d 184, 188 (La. 1997), merely holds that § 22:1973 creates an exclusive cause of action for *third parties* because no judicial cause of action for third parties existed before the statute's enactment. Second, and more importantly, the district court's holding is at odds with the Louisiana Supreme Court's recent decision in *Kelly v. State Farm Fire & Cas. Co.*, 2014–1921, 169 So. 3d 328, 336–37, 2015 WL 2082540, at *7 (La. 5/5/15).
>
> In *Kelly* the Louisiana Supreme Court extended the logic of *Theriot* and held that "an *insured's* cause of action for a breach of the implied covenant of good faith and fair dealing is not limited to the prohibited acts listed in La. R.S. 22:[1973](B)." *Id.* (quoting *Stanley v. Trinchard*, 500 F.3d 411, 427 (5th Cir. 2007)). The difference between the third parties in *Theriot* and the insureds in Kelly is that the third parties' right to bring causes of action against insurers was created by § 1973, whereas insureds' right to bring a cause of action for breach of the duty of good faith and fair dealing preceded § 1973. *See, e.g., Pareti v. Sentry Indem. Co.*, 536 So. 2d 417, 423 (La. 1988).
>
> The district court did not consider whether Sohum properly alleged a breach of Century's good faith and fair dealing obligation under Louisiana Law other than

> La. Rev. Stat. § 22:1973. As a result, we reverse the district court's dismissal of Sohum's bad faith counterclaim and remand for reconsideration of whether, in light of *Kelly,* Sohum has pleaded a claim under Louisiana law.

Id. at 371—72.

Prescriptive Period: *Belanger v. Geico Insurance Co.*, 623 F. App'x. 684 (5th Cir. 2015) demonstrates how the law is uncertain on the prescriptive period that applies for a bad faith claim by an insured against an insurer under La. Rev. Stat. § 22:1973.

On December 27, 2007, Belanger was injured in an automobile accident by Stephen, GEICO's insured. *Id.* at 685. Belanger sued Stephen and GEICO alleging that he offered to settle his claim against both for the policy limits of $25,000, but GEICO rejected his offers. *Id.* The matter proceeded to trial, and the court entered a judgment against Stephen in the amount of $450,000 and against GEICO for the policy limits. *Id.* "The trial court denied the defendants' motion for post-judgment relief on September 8, 2011, and entered a signed order to that effect on November 17, 2011." *Id.*

GEICO appealed suspensively, but Stephen appealed the $450,000 judgment devolutively. *Id.* The Louisiana First Circuit Court of Appeal affirmed the trial court's decision, and, on April 1, 2013, the Louisiana Supreme Court denied the defendants' application for a writ of certiorari. *Id.* at 686.

GEICO paid Belanger the $25,000 policy limits. *Id.* Later, "Belanger entered into a written compromise agreement with Stephen, in which Stephen assigned Belanger any rights she had against GEICO concerning GEIGO's alleged bad faith handling of her claim which resulted in the excess judgment against her." *Id.*

Belanger then sued GEICO in state court on October 4, 2013, asserting the claim he acquired from Stephen. *Id.* GEICO removed the case to federal court on November 20, 2013,

more than one year after the entry of the judgment against Stephen but less than one year after the Louisiana Supreme Court denied the defendants' application for a writ of certiorari. *Id.* The district court concluded that the claim was time-barred because the claim arose when the excess judgment was entered against Stephen, more than one year before the action was filed. *Id.*

Belanger appealed and continued to argue that the claim did not arise until the Supreme Court denied the writ. *Id.* Belanger also argued, for the first time on appeal, that the applicable prescriptive period is ten years rather than one year. *Id.*

The Fifth Circuit framed the issues of the case as follows:

> This appeal concerns when the claim asserted by Belanger arose, and what prescriptive period is applicable to that claim. If, as Belanger argues, the claim did not arise until the Louisiana Supreme Court denied a writ, less than one year before Belanger filed this suit, then it is timely even under the one-year prescriptive period applied by both parties and the district court below. If, however, it arose when the excess judgment was entered against Stephen, more than one year before Belanger filed suit, then the length of the prescriptive period alone will determine whether the claim is timely.

Id. at 687.

The Fifth Circuit began its analysis by explaining how the district court had concluded that the claim arose the day the state trial court entered the excess judgment against Stephen. *Id.* at 687. The Fifth Circuit quoted the following from the district court:

> While neither party cited any Louisiana Supreme Court or appellate court cases that addresses this specific issue, the case cited by the defendant, *Mathies v. Blanchard*, 2006-0559 (La. App. 1 Cir. 2/21/07); 959 So.2d 986, is persuasive. In *Mathies*, the Louisiana First Circuit Court of Appeal found that entry of the judgment on the principal demand in excess of the policy limits harms the insured and gives rise to the right to enforce the cause of action for a[n] insurer's bad faith failure to settle a claim against its insured within the policy limits. Although the appellate court was addressing the issue of prematurity rather than prescription of the claim, the court established that the injury/damage arising from an insurer's bad faith refusal to settle was sustained at the time an excess judgment was entered. Because the allegations in the Petition show that the Petition was filed more than one year after the state court entered an excess judgment, the burden shifted to the plaintiff to show that prescription was interrupted by the state court appeal process or did not commence on the date of the judgment.

Belanger, 623 F. App'x at 687. The Fifth Circuit found that the "district court's reliance on *Mathies* appears to be well founded." *Id.* The Fifth Circuit asserted that *Mathies* was "high persuasive" and quoted the following from it:

> While Louisiana courts have recognized a cause of action against an insurer for bad faith failure to settle a claim against its insured within the policy limits, no Louisiana court has been called upon to determine when the right to enforce the cause of action arises. However, numerous courts in other jurisdictions have squarely addressed the issue, and have repeatedly held that an excess judgment is a prerequisite to an action for bad faith failure to settle a claim against an insured within the policy limits. *See Romstadt v. Allstate Insurance Company,* 59 F.3d 608, 611 (6 Cir. 1995); *Kelly v. Williams*, 411 So.2d 902, 904 (Fla. App. 5 Dist. 1982); *Crabb v. National Indemnity Company*, 87 S.D. 222, 231, 205 N.W.2d 633, 638 (S.D. 1973); *Amoco Oil Company v. Reliance Insurance Company*, 1998 WL 187336 (W.D. Mo. 4/14/98); *Ragas v. MGA Insurance Company*, 1997 WL 79357 (E.D. La. 2/21/97).

Belanger, 623 F. App'x at 688 (quoting *Mathies*, 959 So.2d at 988). The Fifth Circuit found that "the key question in all of these cases was whether the insured had been exposed to liability as a result of an excess judgment." *Id.*

The Fifth Circuit then reasoned that, "[b]ecause the question under *Mathies* [was] when the insured became legally obligated to pay the excess judgment, the outcome turns on how the underlying action was appealed." *Id.* Here, the excess judgment was appealed devolutively; therefore, the judgment was fully enforceable during the appeals process. *Id.* at 689. Thus, if the applicable prescriptive period is one year, Belanger's action was untimely. *Id.*

Belanger also argued for the first time on appeal that the ten-year prescriptive period for contract actions should apply. *Id.* Bad faith claims asserted by third parties against the insurer are undisputedly subject to the one-year prescriptive period. *Id.* at 690 (citing *Zidan v. USAA Property & Cas. Ins. Co.*, 622 So. 2d 265, 266 (La. App. 1 Cir. 5/28/93)). But Louisiana state courts have never specifically addressed the applicable prescriptive period with respect to bad faith claims by the insured or her assignee. *Id.* The

Eastern District of Louisiana applied the one-year prescriptive period from *Zidan* to claims by an insured in several cases. *Id*. (citing *Marketfare Annunciation, LLC v. United Fire & Cas. Co.*, No. 067232, 2007 WL 837202 (E.D. La. 2007); *Brown v. Protective Life Ins. Co.*, 353 F. Supp. 2d 739 (E.D. La. 2004); and *Yates v. Sw. Life Ins. Co.*, No. 97-3204, 1998 WL 61033 (E.D. La. 1998)). However, the prescriptive period in *Zidan* did not concern a claim by an insured and thus did not determine the issue at hand. *Id*. In *Aspen Specialty Insurance Co. v. Technical Industries, Inc.*, No. 12-02315, 2015 WL 339598 (W.D. La. 2015), the Western District of Louisiana concluded that the prescriptive period for first-party claims is ten years. *Belanger*, 623 F. App'x at 690.

Ultimately, the Fifth Circuit concluded that "the question of which prescriptive period applies to a bad faith claim by an insured against an insurer under La. Rev. Stat. § 22:1973 may be ripe for consideration, but not under these circumstances." *Id.* at 691. Belanger's case was time-barred under the one-year prescriptive period because he had waived his argument that the claim is subject to a ten-year prescriptive period. *Id.* at 691—92.

F. Hypothetical: Settlement of an Arguably Frivolous Claim?

Kelly involve an insurance company refusing to settle a claim that led to an excess judgment against the insured. Most bad-faith cases appear to fall into this category.

But what if the inverse happened? That is, what if an insurer settled a claim that potentially lacked merit, and, as a result, the insured's premiums went up? Would the insured have a cause of action for bad faith?

To reiterate, La. Rev. Stat. § 1973(A) provides that "[a]n 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 claimant[.]" The insurer is liable for a breach of these duties. *Id.* Thus, under the plain language of the statute, the insurer has an "affirmative duty to adjust claims fairly," but it must "make a reasonable effort to settle claims with" claimants. *Id.* Thus, the viability of this cause of action is unclear from the statute itself.

Kelly contains certain language supporting such a claim. "The first sentence of Subsection A of the statute recognizes the jurisprudentially established duty of good faith and fair dealing owed to the insured, which is an outgrowth of the contractual and fiduciary relationship between the insured and insurer." *Kelly*, 169 So. 3d at 336 (quoting *Theriot*, 695 So. 2d at 187). "[A] liability insurer is the representative of the interests of its insured and the insurer, when handling claims, must carefully consider not only its own self-interest, but also its insured's interest so as to protect the insured from exposure to excess liability." *Id.* at 338 (citing *Smith*, 679 So. 2d at 376). *Kelly* further recognized:

> [T]he insurer has undertaken the obligation to protect the insured. 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

Id. at 341 (citations, quotations, and alterations omitted). Thus, *Kelly* strongly emphasizes the duties owed to the insured by the insurer, and, as a fiduciary, the insurer may have duties that prevent it from settling claims that are potentially devoid of merit.

Moreover, *Smith* could be read to allow such a claim. Again, the *Smith* court identified several factors to consider for bad-faith claims:

> The determination of good or bad faith in an insurer's deciding to proceed to trial involves the weighing of such factors, among others, as the probability of the insured's liability, the extent of the damages incurred by the claimant, the amount

> of the policy limits, the adequacy of the insurer's investigation, and the openness of communications between the insurer and the insured.

679 So. 2d at 377. Each of these factors would be relevant to deciding whether an insurer breached its duty of good faith when settling an unmeritorious claim.

On the other hand, parts of *Kelly* and *Smith* would also support denying a claim for settlement of a potentially frivolous claim. *Smith* stated "In the absence of bad faith, a liability insurer generally is free to settle or to litigate at its own discretion, without liability to its insured for a judgment in excess of the policy limits." 679 So. 2d at 376 (citing 15 William Shelby McKenzie & H. Alston Johnson, III, *Louisiana Civil Law Treatise–Insurance Law and Practice* § 218 (1986)). Though the *Smith* court identified factors to consider in determining if there has been bad-faith, the Supreme Court made the following qualification:

> Nevertheless, when an insurer has made a thorough investigation and the evidence developed in the investigation is such that reasonable minds could differ over the liability of the insured, the insurer has the right to choose to litigate the claim, unless other factors, such as a vast difference between the policy limits and the insured's total exposure, dictate a decision to settle the claim.

Id. The inverse would logically be true; if reasonable minds could differ, the insurer has a right to choose *not* to litigate the claim. Lastly, despite its holding, *Kelly* cautioned that "tight reigns must be kept on a cause of action for insurer settlement practices," that "the law of bad faith should be cautiously applied," that La. Rev. Stat. § 22:1973 "should be strictly construed," and that "[a] strict application of the statute does not contemplate gamesmanship" and " 'set[ting] up' the insurer." *Kelly*, 169 So. 3d at 344 n. 34.

Ultimately, "the determination of whether the insurer acted in bad faith turns on the facts and circumstances of each case." *Smith*, 679 So. 2d at 377. The latter position seems stronger, but a firm answer to the question cannot be given in a vacuum without the development of a factual record. Nevertheless, *Kelly* and *Smith* show where the battle lines would be drawn.

IV. Conclusion

The last few years have been good for the collateral source rule and insurance bad faith claims. *Hoffman v. 21st Century North America Insurance Co.* laid out the right approach for addressing collateral source issues. Attorneys should:

(1) address the *Bellard* and *Bozeman* considerations of

a. whether application of the rule will further the major policy goal of tort deterrence, and

b. whether the victim either paid for the benefit of his collateral source or suffered some diminution in his or her patrimony because of the availability of the benefit, such that no actual windfall or double recovery would result from application of the rule;

(2) turn to the principles of the Civil Code and ensure conformity therewith; and

(3) analyze other policy considerations.

In the bad faith area, *Kelly* definitely recognized a cause of action under La. Rev. Stat. § 22:1973(A) and provided guidance for interpreting subsection (B)(1). In *Century Surety Co.* and *Belanger*, the United States Fifth Circuit recognized that courts are still feeling their way out in interpreting the *Kelly* decision and in deciding the issue of prescription. Careful consideration of these potential claims will help maximize an injured client's recovery.