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Insurance

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Intentional Injury

During an old-timer's softball game, "Bug" Schilling was caught in a run down between second and third base. While making the tag, the third baseman, William Breland, narrowly escaped collision with the aggressive base runner. While Schilling lay prone after his slide into third base, Breland "either dropped, tossed, or threw the softball" in his direction, striking Schilling on the chin. After an exchange of words, Schilling shattered Breland's jaw with a single punch. Schilling had personal liability coverage under a homeowner's policy that excluded coverage for "bodily injury or property damage which is either expected or intended from the standpoint of the insured." The insurer denied coverage for Breland's claim. In response to interrogatories, the trial jury found that Schilling did not intend the bodily injury to Breland.[1] In affirming the judgment against the insurer, the Louisiana Supreme Court in *Breland v. Schilling*[2] applied a new subjective standard in determining whether the common policy exclusion for intentional injury was applicable.

In an earlier decision, *Pique v. Saia*,[3] the court construed the provision to exclude only intentional injury. Borrowing the standard for an intentional act developed in *Bazley v. Tortorich*,[4] the court defined an intentional injury as the product of an intentional act. *Bazley* involved

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1. The jury also apportioned fault between the parties, assigning 75% to Schilling and 25% to Breland.
2. 550 So. 2d 609 (La. 1989).
3. 450 So. 2d 654 (La. 1984).
4. 397 So. 2d 475 (La. 1981). In *Pique*, the court defined an intentional injury as follows:

> An injury is intentional, i.e., the product of an intentional act, only when the person who acts either consciously desires the physical result of his act, whatever the likelihood of that result happening from his conduct; or knows that that result is substantially certain to follow from his conduct, whatever his desire may be as to the result.

450 So. 2d at 655.

interpreting the phrase "an intentional act" within the meaning of workers' compensation law.[5]

Without discussing its earlier decision in *Pique*, the *Breland* court found that the policy language "emphasizes that an excluded injury is one which the insured *intended*, not one that the insured *caused*, however intentional the injury-producing act . . .," so that "[t]he subjective intention and expectation of the insured determine which injuries fall within and which fall beyond the scope of coverage under this policy."[6] The court expressly found the objective tort standard set forth in *Bazley* inapplicable[7] and suggested that an insurance purchaser would not reasonably expect coverage for an injury that he intended, whether slight or grave, but that the purchaser would expect to be protected from unexpected serious injury when only minor injury was intended. The court then articulated the following standards for application of the intentional injury exclusion:

> We hold, therefore, that when minor injury is intended, and such results, the injury is barred from coverage. When serious injury is intended, and such results, the injury is also barred from coverage. When a severe injury of a given sort is intended, and a severe injury of any sort occurs, then coverage is also barred. But when minor injury is intended, and a substantially greater or more severe injury results, whether by chance, coincidence, accident, or whatever, coverage for the more severe injury is not barred. Whether a given resulting bodily injury was intended from the standpoint of the insured within these parameters is a question of fact. Such factual determinations are the particular province of the trier of fact, in this instance the trial jury.[8]

The court affirmed the judgment upon finding that the record supported the jury's conclusion that the defendant did not have the requisite subjective intent to injure the plaintiff.[9]

The subjective standard enunciated by the *Breland* court for determining whether an intentional act is covered by a policy cannot be easily

5. Under La. R.S. 22:1032 (1982), the exclusive remedy provisions of the workers' compensation act do not apply to liability "resulting from an intentional act."

6. 550 So. 2d at 611.

7. Id. It also distinguished Caudle v. Betts, 512 So. 2d 389 (La. 1987), which held that an electrical shock administered as a practical joke was an "intentional act" within the meaning of the workers' compensation act even though the actor had not intended any physical injury.

8. 550 So. 2d 609, 614 (La. 1989).

9. Id. The court referred to the defendant's testimony that he was just trying to protect himself, that he didn't intend to break the plaintiff's jaw or do him any serious harm, and that the broken jaw was just a "freak accident."

applied by the courts. The court's subjective standard invites the "I didn't mean to do it" defense and will be more difficult to apply than an objective standard. Judges and juries probably will disregard such a defense uttered from the lips of an insured who wielded a deadly weapon. It will be more difficult, however, to evaluate the subjective intent of a brawl participant who, after the anger has cooled, will contritely plead he did not intend the injury actually inflicted. This question, then, becomes whether *Breland* will permit insurance coverage only for the truly unusual and unexpected injury.

In *Menard v. Zeno*,[10] the first case to apply *Breland*, the third circuit deemed that the intentional injury exclusion precluded coverage for the insured's homosexual rape of an eight year old boy. Specifically, the court found the psychological injuries suffered by the boy were "consistent with the clinical picture of a child sexually abused, as opposed to the 'freak' and unintended injuries suffered in *Breland*."[11]

In *Jones v. Thomas*,[12] the supreme court had held that an employer may be vicariously liable for the intentional act of an employee which injures a co-employee. In a sequel to that decision, the fourth circuit held that the employer's liability was not covered under its comprehensive general liability policy because that policy excluded coverage for "bodily injury to an employee of the insured arising out of and in the course of his employment by the insured."[13] Coverage for an employer's liability to his own employees is generally provided under a Workers' Compensation/Employer's Liability Policy.

Primary and Excess Insurers

In *Great Southwest Fire Insurance Company v. CNA Insurance Companies*,[14] the court established rules governing the relationship between primary and excess liability insurers. A substantial difference of opinion exists in recent Louisiana state and federal court decisions concerning whether a primary insurer owes any duties to an excess insurer.[15] In *Great Southwest*, the issue arose out of a personal injury

10. 558 So. 2d 744 (La. App. 3d Cir.), writ denied, 561 So. 2d 121 (1990).

11. Id. at 748. In Williamson v. Historic Hurtsville Ass'n, 556 So. 2d 103 (La. App. 4th Cir. 1990), without reference to *Breland*, the fourth circuit reversed a summary judgment in favor of a homeowner's insurer, suggesting that injuries resulting from the insured's allegedly defamatory statement may not have been intentional.

12. 426 So. 2d 609 (La. 1983).

13. Jones v. Thomas, 557 So. 2d 1015 (La. App. 4th Cir. 1990).

14. 557 So. 2d 966 (La. 1990).

15. Cf. Twin City Fire Ins. Co. v. CNA Ins. Co., 711 F. Supp. 310 (W.D. La. 1988), rev'd 904 F. 2d 703 (5th Cir. 1990); Pacific Employers Ins. Co. v. United General Ins. Co., 664 F. Supp. 1022 (W.D. La. 1987); and Laper v. Board of Comm'rs of Port of New Orleans, 523 So. 2d 926 (La. App. 4th Cir.), writ denied, 531 So. 2d 275 (1988)

claim against Contract Cleaners, whose primary liability insurer was Transportation Insurance Company and whose excess insurer was Great Southwest. Transportation's unsuccessful defense of Contract Cleaners resulted in a judgment in the principal sum of $396,000. Transportation paid its primary policy limits of $300,000, and Great Southwest was responsible for the remainder. Great Southwest sought to recover its expenditures from Transportation on the ground that its loss resulted from Transportation's bad faith failure to settle within the policy limits and to properly defend the interests of the insured. Great Southwest contended that it was entitled to recover from Transportation both in its own right and as the insured's subrogee.

The court held that a primary carrier does not owe a duty to the excess carrier in the defense and settlement of claims against their common insured. The court concluded that it was unsound to create a delictual duty of care or good faith performance owed by the primary insurer to the excess insurer.[16] The court did, however, indicate that an excess insurer may become conventionally or legally subrogated to the insured's rights against the primary insurer under certain circumstances. If the primary insurer breaches duties owed to the insured, the primary insurer may become solidarily liable with the excess insurer for the portion of the judgment in excess of the primary policy limits. Upon satisfaction of that solidary obligation, the excess insurer would be subrogated to the insured's rights against the other solidary obligor, the primary insurer.

After establishing that the excess insurer may be subrogated to the insured's rights where the primary and excess insurer have been solidary obligors, the court described how the obligation should be apportioned between the two solidary obligors. When the primary insurer's bad faith failure to perform caused the excess judgment, the court concluded that the primary insurer should be considered the principal obligor and thus liable to the excess insurer for reimbursement of the whole debt.

Because the court considered only the primary insurer's exception to the excess insurer's suit, the court did not determine whether the

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with National Union Fire Ins. v. Liberty Mutual Ins., 696 F. Supp. 1099 (E.D. La. 1988); Insurance Co. of North America v. Home Ins. Co., 644 F. Supp. 359 (E.D. La. 1986) and Southern America Ins. v. Hartford Acc. & Indem. Co., 498 So. 2d 280 (La. App. 1st Cir. 1986), writ denied, 500 So. 2d 425 (1987).

16. In a companion case, Gibbs v. Liberty Mutual Ins. Co., 557 So. 2d 972 (La. 1990), the court answered in the negative the following question certified from the United States Fifth Circuit Court of Appeals: "Does the primary insurer owe a duty to the excess insurer similar to the duty it owes to its insured, to act reasonably and in good faith?" In *Great Southwest*, 557 So. 2d at 971, the majority opinion concluded with the observation that, "[i]n a proper case, it may be possible for the excess carrier to recover directly from the primary insurer for damage caused by an abuse of right." Without further explanation, the court noted that such theory would require pleading and proof of factors not alleged in this action.

primary insurer actually breached any duty owed to the insured that would render the primary insurer solidarily liable with the excess insurer for the amount of the judgment in excess of the primary limits. *Great Southwest*, however, does establish the ground rule that future claims by excess insurers must be based upon their subrogation to the insured's rights against the primary insurer because no duty is owed by the primary insurer directly to the excess insurer.

PENALTY STATUTES

In both the 1989 and 1990 legislative sessions, considerable interest was taken in regulating the handling and payment of claims by insurers. In 1989, the legislature amended the general penalty statute, Louisiana Revised Statutes 22:658, to reduce the payment period from 60 to 30 days, to add duties to pay claims of third parties for property damage and medical expenses within 30 days of written settlement and to compensate third parties for loss of use of personal vehicles.[17] The legislature also amended the Unfair Trade Practices Act to define and sanction "unfair claims settlement practices" by insurers.[18]

Activity in the insurance claims area continued in 1990 with the enactment of Louisiana Revised Statutes 22:1220 which provides that an insurer "owes to his insured a duty of good faith and fair dealing" and has "an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or claimant, or both."[19] The statute defines five acts which, if knowingly committed, constitute a breach of these duties, including (1) misrepresenting facts or policy provisions, (2) failing to pay a written settlement within 30 days, (3) denying coverage based on an application altered without the insured's knowledge, (4) misleading a claimant as to the applicable prescriptive period or (5) failing to pay an insured, without probable cause, within 60 days after receipt of satisfactory proof of loss. In addition to any general or special damages resulting from such breach, the claimant may be awarded penalties not to exceed two times the damages sustained or $5,000, whichever is greater.[20]

The legislature's patchwork approach to solving perceived problems with the handling of claims by insurance companies aggravates and

17. 1989 La. Acts No. 638, § 1.

18. La. R.S. 22:1214, :1217 (1982) as amended by 1989 La. Acts No. 638, § 1.

19. 1990 La. Acts No. 308, § 1.

20. Also, La. R.S. 22:658 (1978) was amended by 1990 La. Acts Nos. 262, § 1 and 955, § 1. Act 262 was a technical amendment to clarify that the 30 day payment period was triggered by either satisfactory proof of loss *or* written settlement agreement. Act 955 added a provision for penalties and attorneys fees for the failure to pay, without probable cause, for alternative transportation.

illustrates the need for comprehensive revision of the Insurance Code. Because the last comprehensive revision of the Insurance Code occurred in 1958, many areas of the Insurance Code have been plastered with a confusing array of legislative bandaids. As a result, the entire Code needs careful and coordinated study and treatment.

Direct Action Statute

Two interesting decisions occurred during this term involving the Direct Action Statute, Louisiana Revised Statutes 22:655. The Louisiana Supreme Court decision in *Quinlan v. Liberty Bank and Trust Company*,[21] superficially straightforward and unremarkable, prompted an unusually vigorous dissent which bears examination. In that case, plaintiffs asserted a right of direct action against an insurer who had issued a "directors' and officers' liability policy" because a bank officer insured under the policy allegedly was negligent in managing their funds. Despite its name, the policy contained a number of provisions which were arguably inconsistent with the usual liability policy. The policy language appeared to disavow any defense obligation and considered the costs of defense a part of the liability limits rather than expenses beyond the stated liability limits. Both the trial court and the court of appeal[22] determined that the policy was simply an indemnity policy thereby indicating that the insurer was not subject to a direct action by third-party claimants such as the plaintiffs.

In a very brief opinion, the supreme court reversed the lower court's decision; however, two justices joined in a lengthy and vigorous dissent in which the history surrounding Louisiana's Direct Action Statute is discussed. Both the majority and the dissenting opinion contain valid points and are not necessarily in conflict with one another.

The main theme of the dissent is that the insurance contract by its provisions (as opposed to its "caption," to which the majority opinion made reference) clearly envisioned an "indemnity" obligation as opposed to a "liability" obligation. That the insurer intended the policy to be an indemnity policy rather than a liability policy seems reasonably clear, and to that extent the dissenting justices are correct; however a second and ultimately more crucial question is whether the public policy underlying the Direct Action Statute will permit the terms of the policy to prevail in this instance.

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21. 558 So. 2d 221 (La. 1990).

22. Quinlan v. Liberty Bank and Trust Company, 545 So. 2d 1140 (La. App. 4th Cir.), writ granted, 550 So. 2d 637 (1989), and rev'd by 558 So. 2d 221 (1990).

Throughout the history of the Direct Action Statute courts have invalidated policy provisions[23] that purport to limit an insured's recourse against an insurance company because of the fact of the statutory provisions. Assertions that the insurance policy demands that no direct action may be had against the insurer proved to be an insufficient argument to defeat an action authorized by the Direct Action Statute. Thus, the dissenters' analysis of the policy provisions, while certainly proper and arguably correct, does not resolve the ultimate question of whether a direct action against the insurer, in fact, exists. Although a policy may imply that no right of direct action exists, the policy, itself, may not comply with the terms of the statute, and therefore may be invalid.

Unfortunately, the majority opinion does not address the second question in much detail at all. Furthermore, the majority position would have been more persuasive had the majority recited the jurisprudential history of the statute to reveal that protection against the bankruptcy of the insured[24] is no longer the only reason for the existence of the right of direct action. Rather, it would appear that we in Louisiana have simply chosen a direct method of dealing with the allocation of loss and have recognized the pervasive reach of insurance into risks that are not casualty-related and do not implicate the insolvency of the insured.

Again, the dissent offers some interesting food for thought. Noting that "a duty to defend is the hallmark of a liability policy,"[25] the dissenters focus on (1) the absence of any clear defense obligation and (2) the inclusion of defense costs in the policy limits rather than paying them beyond the limits as indications that the policy in question could not be a liability policy. Since a current trend is to include defense costs in the policy limits, thereby merging the defense and indemnity obligations in the policy and offering the insured less total coverage for the same premium,[26] it is possible that the Direct Action Statute might

23. See generally W. McKenzie & H. Johnson, Louisiana Insurance Law and Practice § 26, in 15 Louisiana Civil Law Treatise (1986) (the "no-action" clause and the "late notice" clause).

24. A factor cited by the dissenters and thought unlikely to be present with a bank as an insured, which is itself a doubtful premise.

25. 558 So. 2d at 230.

26. The professional malpractice policy offered by Home Insurance Company to Louisiana lawyers at the time this is written, unlike the predecessor policy issued by New England Insurance Company, is a policy which includes defense expenses in the policy limits. This raises a variety of interesting questions, not the least of which is whether the need of the insured for personal counsel is enhanced to assure that the company wisely spends its defense dollar to protect the insured to the greatest extent possible. If the defense expenses are not carefully husbanded, the insured could find himself on the eve of trial with no indemnity coverage whatsoever and yet no clear way out of the ongoing litigation.

soon be amended, either to codify or to overrule the result in *Quinlan*. If, however, the dissent is considered correct and the Direct Action Statute is not amended, the reach of that provision might be substantially curtailed, thus radically changing the face of Louisiana insurance litigation.

The other decision involving the Direct Action Statute raises long-dormant issues of late notice of the claim. Most policies continue to premise coverage of a claim on the full cooperation of the insured and the early notice of a claim, thereby implying that coverage might be denied if the insured is "late" in providing notice of the claim. What "late" means is open to discussion, but in Louisiana courts, insurers have rarely been successful in escaping their obligations. Courts usually require that clear prejudice in defending the claim, a difficult burden to discharge, be demonstrated by the insurer.[27] In very few cases has sufficient prejudice been established.[28]

The subject of late notice was also revisited during this term in *Lodrigue v. Cumis Insurance Society, Inc.*.[29] Plaintiff's wife and minor son were involved in an automobile accident with defendant's insured. Shortly thereafter, plaintiff presented to defendant a very small property damage claim which was paid by the defendant. About eight months later, plaintiff filed a city court suit against the insured for personal injuries to his son and related medical expenses.

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27. See Pomares v. Kansas City Southern Ry. Co., 474 So. 2d 976 (La. App. 5th Cir.), writ denied, 447 So. 2d 1131 (1985) (first notice of accident when service of garnishment petition occurred more than six years after the accident and more than one year after judgment against insured; no prejudice shown; insured had been represented by counsel in tort suit, but lost); Chennault v. Dupree, 398 So. 2d 169 (La. App. 3d Cir. 1981) (no prejudice established when there was no notice until insurer was named in amended petition five years after accident); Miller v. Marcantel, 221 So. 2d 557 (La. App. 3d Cir. 1969) (five-month delay in notice of filing of suit; suit was still pending and insurer had received actual notice of accident and investigated it); Reid v. Monticello, 44 So. 2d 509 (La. App. 1st Cir. 1950) (no prejudice when insured discovered for first time seven months after the incident that he might have coverage and promptly notified the insurer).

28. MGIC Indemn. v. Central Bank of Monroe, 838 F. 2d 1382 (5th Cir. 1988) (failure of insured to give insurer notice until appeal was pending was violation of insured's obligation to give timely notice); Hallman v. Marquette Cas. Co., 149 So. 2d 131 (La. App. 2d Cir. 1963) (omnibus insured in accident; named insured informed insurer; claim brought only against former, and insurer had no notice of it; default judgment taken and never paid; suit then brought against insurer, which successfully defended on ground of late notice, upon showing that it could no longer defend on the merits). See also Elevating Boats, Inc. v. Gulf Coast Marine, Inc., 766 F. 2d 195 (5th Cir. 1985). See generally W. McKenzie & H. Johnson, Louisiana Insurance Law and Practice § 26, in 15 Louisiana Civil Law Treatise (1986).

29. 560 So. 2d 848 (La. App. 3d Cir.), rev'd, 565 So. 2d 426, reh'g denied, 566 So. 2d 384 (1990).

A default judgment against the insured was taken and confirmed about five months after the suit was filed, and within a month after that, plaintiff's counsel asked the insurer to pay the judgment. When the insurer declined, plaintiff filed suit against the insurer, not to make the judgment "executory" but to litigate liability and quantum anew. The insurer first filed exceptions of prescription and res judicata which were overruled. The insurer then filed a motion for summary judgment on the basis of late notice which was granted. The appellate court affirmed.

In an attempt to cure the notice problem, plaintiff argued that the payment of the property damage claim was sufficient notice to the insurer of a potential personal injury claim, but this contention was properly rejected. The plaintiff then provided the affidavit of the insured's mother, who averred that she had given the insurer notice of the incident. The affidavit was rather general and both courts found it insufficient to establish a material issue of fact as to notice. Finding that the case was one of no notice prior to a default judgment being taken, the appellate court held that prejudice to the insurer resulted as a matter of law when the first notice came after the default judgment. This statement, while arguably a sound proposition, is contained in only one other Louisiana case.[30]

If left standing, *Lodrigue* might have signalled a trend away from the narrow interpretation of the late notice clause in policies and might have afforded insurers some measure of relief from defense and indemnity obligations in the exceptional case in which late notice has created problems in defending the claim. But the supreme court granted a writ and reversed the summary judgment in a *per curiam* opinion, on the basis that the mother's affidavit created a genuine issue of material fact appropriate for resolution at trial.[31] This disposition of course permitted the court to pretermit, at least for the moment, an evaluation of the appellate court's treatment of the late notice issue. Apparently, a full discussion of the late notice issue by the supreme court will have to await another day.

Health and Accident Insurance

On the legislative front, health and accident insurance was one of the hottest topics in the 1990 Regular Session of the Louisiana Legislature. Most of the enactments concern business practices of insurers in this field, but insurance counsel should be aware of these changes as well.

30. Hallman v. Marquette Cas. Co., 149 So. 2d 131 (La. App. 2d Cir. 1963).
31. 565 So. 2d 426 (La. 1990).

Act 538[32] requires a group health and accident carrier to give forty-five days notice of an increase in premiums of 20% or more, and sixty days notice of cancellation or nonrenewal of the policy, except for non-payment of premiums. In groups of a hundred persons or more, this requirement may be waived by contract. Act 872[33] expands the jurisdiction of courts competent to hear claims for penalties and attorney's fees relative to health and accident insurance claims beyond the district court in the parish of the domicile of the insured to include any court of "competent" jurisdiction in the parish except justice of the peace courts. Act 879[34] provides a statutory definition of total disability for purposes of disability policies. Finally, Act 641[35] authorizes the Commissioner of Insurance to regulate any entity issuing health care coverage unless the entity can show it is being regulated by another state or federal agency; this should permit the Commissioner to regulate some entities which do not take the form of traditional insurers and have heretofore escaped regulation by the Department of Insurance or perhaps by any other state or federal agency.

One decision of note occurred during this term in the health and accident insurance field, involving the obligations of an insurer to pay expenses for alcoholism, drug abuse and related mental disorders. In *Hargroder v. Protective Life Insurance Company*,[36] the insurer had rejected most of the claimed expenses on behalf of the insured and two of his children for alcohol and drug abuse treatment. The dispute centered around the statutory requirement[37] that a health and accident insurer offer coverage for these problems as an option to the policyholder. The evidence indicated that the policyholder was the insured's employer—the local school board; that the insurer presented the school superintendent, a school board employee, the option to include substance abuse treatment coverage for a higher premium; and that the superintendent, but not the board itself, rejected such coverage.

Plaintiff contended the statute required that the *policyholder* reject the offered coverage. The plaintiff reasoned, therefore, that since the superintendent was neither policyholder nor authorized agent of the policyholder, the proffered coverage was never properly rejected and was available to cover the disputed claims.

Both the trial court and the appellate court agreed with that contention, albeit for slightly different reasons. The appellate court rejected

32. 1990 La. Acts No. 538. See also 1990 La. Acts Nos. 877 § 1 and 886 § 1, which provide for the same general subject matter.
33. 1990 La. Acts No. 872 § 1.
34. 1990 La. Acts No. 879 § 1.
35. 1990 La. Acts No. 641 § 1.
36. 556 So. 2d 991 (La. App. 3d Cir.), writ denied, 559 So. 2d 1637 (1990).
37. La. R.S. 22:215.5 (Supp. 1990).

the notion that the policy afforded coverage for substance abuse treatment costs unless specifically rejected by the policyholder. Rather, the court analogized this case to those arising under the provisions governing uninsured motorist coverage, concluding that public policy requires that rejection of substance abuse expense coverage must be made in "absolutely proper form."[38] In the absence of such "form"—a term not statutorily specified beyond that the rejection must be made by the policyholder—[39]the offered coverage will be deemed to have been accepted. The net result of *Hargroder* is an extension of the rationale espoused in *Rudloff v. Louisiana Health Services & Indemnity Company*,[40] where the court deemed that the statutorily-required coverage existed although the carrier had never made the offer and thus the carrier could not have either accepted or rejected.

Borrowing the rationale utilized in the context of uninsured motorist coverage and applying that reasoning to the area of substance abuse coverage under a health and accident policy is an interesting judicial technique. This approach, however, lacks jurisprudential support and attorneys should be cognizant of its use in future cases.

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38. 556 So. 2d at 997.

39. La. R.S. 22:1406(D)(1) (1978) contains rather elaborate provisions on the proper form, fleshed out in great detail by the cases.

40. 385 So. 2d 767 (La. 1979).