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W. Shelby McKenzie

H. Alston Johnson

INSURANCE LAW

W. Shelby McKenzie and*
*H. Alston Johnson**

LIABILITY INSURANCE

Obligation to Defend

In its well-reasoned opinion in *Pareti v. Sentry Indemnity Co.*,[1] the supreme court provided the answer to a previously unresolved question: whether the insurer could terminate its obligation to defend its insured upon exhaustion of its policy limits. Under liability coverage, insurers generally assume the duty to defend the insured. Usually, the insurer agrees to pay the cost of defense in addition to the liability policy limits.[2] Modern liability policies often contain a provision under which the obligation to defend terminates upon full payment of the liability policy limits. Prior to *Pareti*, Louisiana decisions had not determined the validity and effectiveness of such provisions.

In *Pareti*, the plaintiffs brought suit against the Schnellers and their liability insurer for damages arising out of an automobile accident. The plaintiffs also named their own uninsured motorist (UM) carrier as a defendant. The UM carrier filed a cross-claim for reimbursement against the Schnellers. Upon settlement for the liability policy limit of $50,000, the plaintiffs released the Schnellers and the liability insurer, but reserved their rights against their own UM carrier. Subsequently, when the UM carrier continued to pursue the cross-claim against the Schnellers,[3] the

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* Adjunct Professors of Law, Louisiana State University; Members, Louisiana State Bar Association.

1. 536 So. 2d 417 (La. 1988). See also, Bohn v. Sentry Ins. Co., 681 F. Supp. 357 (E.D. La. 1988), aff'd, 868 F.2d 1269 (5th Cir. 1989).

2. Policies providing only excess liability coverage may not contain an obligation to defend claims covered by primary insurance. See, e.g., Hobbs v. Fireman's Fund Am. Ins. Companies, 339 So. 2d 28 (La. App. 3d Cir. 1976), writ denied, 341 So. 2d 896 (1977). Also, excess insurers who assume the defense of the insured usually do so under policy provisions that seek to include defense costs within the liability policy limits. Cf. Hartford Accident & Indem. Co. v. United General Ins., 855 F.2d 228 (5th Cir. 1988).

3. The UM insurer continued to pursue the cross-claim after the release of the Schnellers on the authority of Moncrief v. Panepinto, 489 So. 2d 938 (La. App. 5th Cir. 1986). *Moncrief* was later "disapproved" by Bosch v. Cummings, 520 So. 2d 721 (La. 1988), holding that the UM carrier had no independent right to seek reimbursement from the underinsured tortfeasor after the tortfeasor was released by its insured.

liability insurer advised the Schnellers that it would no longer provide them with a defense, citing the following policy provision:

> Our duty to settle or defend ends when our limit of liability for this coverage has been exhausted.[4]

The Schnellers filed a cross-claim against their liability insurer alleging breach of the duty to defend. This cross-claim was dismissed by the trial court, but that judgment was reversed by the court of appeal upon its finding that the policy provision was ambiguous. The supreme court reversed and reinstated the judgment of the trial court dismissing the cross-claim.

The supreme court found that the insurance policy was not ambiguous in that it clearly expressed the intent to terminate the obligation to defend upon exhaustion of the policy limits. The payment of the settlement had exhausted the policy limits. The court concluded that the policy provision was enforceable unless it was in conflict with statutory law or public policy. Finding no applicable statutory law, the court considered the public policy issue by reviewing a number of decisions from other jurisdictions. It found that an apparent sharp division among these jurisdictions arose out of an earlier generation of liability policies that did not contain an express provision concerning the termination of the duty to defend. The court suggested that the modern policy language rendered that jurisprudence moot. It also distinguished the line of cases from other jurisdictions that held that a mere tender of the policy limits, not in payment of settlement or judgment, was not sufficient to terminate the obligation to defend.[5] The insurer in *Pareti* had paid its policy limits in funding a settlement. Finding that there were no public policy concerns to affect its validity, the court in *Pareti* held that the unambiguous policy provision was enforceable.

The court pointed out that it was not necessary to void an unambiguous policy provision to protect against the risk that an insurance company would enter into an inappropriate settlement to avoid the obligation to defend. It emphasized that 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."[6]

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4. 536 So. 2d at 420.

5. Some modern liability policies provide that the duty to defend will be terminated only if the policy limits are exhausted "by payment of judgments or settlements." The court in *Pareti* observed: "When an insurer merely tenders its limits without obtaining a settlement of any claim for its insured, a strong argument can be made that it has neither 'exhausted' its policy limits nor fulfilled its fiduciary duty to discharge its policy obligations to the insured in good faith." Id. at 422-23.

6. 536 So. 2d at 423. See Holtzclaw v. Falco, Inc., 355 So. 2d 1279 (La. 1977); Richard v. Southern Farm Bureau Casualty Ins. Co., 254 La. 429, 223 So. 2d 858 (1969).

The court emphasized that "[a]n insurer which hastily enters a questionable settlement simply to avoid further defense obligations under the policy clearly is not acting in good faith and may be held liable for damages caused to its insured."[7] The court also pointed out that the insurer who in good faith exhausts its policy limits must also "make every effort to avoid prejudicing the insured by the timing of its withdrawal from the litigation."[8] Thus, while enforcing the unambiguous policy provision, the court appropriately cautions insurers that they must discharge their policy obligations in good faith as a prerequisite to the enjoyment of the benefits of that provision.

Exclusion/Affirmative Defense

Recent decisions of the first and fourth circuits have announced that exclusions in liability insurance policies are affirmative defenses that must be specially pleaded. In absence of such pleading, the insurer cannot offer proof in support of the exclusion.[9] These decisions seem to indicate that the common practice of generally pleading that the policy is the best evidence of its content will not be sufficient. While the opinion is not entirely clear, it seems that the insurer in the first circuit decision, who had failed to plead its exclusions, was not permitted to assert that its exclusions were applicable to the facts actually presented at trial.

These decisions seem unduly technical, particularly where the issue is the applicability of an express exclusion to the facts proved by the plaintiff asserting the claim. The exclusions are an integral part of the contract under which the plaintiff seeks to recover and about which he should be knowledgeable. If the plaintiff has any uncertainty as to the position of the insurer, he can protect himself from ambush through discovery. In light of these decisions, however, it is advisable for the insurer to specially plead any specific policy provisions relevant to its defense.

UNINSURED MOTORIST COVERAGE

Self-Insurance

Under UM coverage, the insurer agrees to pay the insured the damages that he is entitled to recover from the owner or operator of

7. 536 So. 2d at 423.

8. Id.

9. Griffin v. Schwegmann Giant Supermarkets, 542 So. 2d 710 (La. App. 4th Cir. 1989); Nippert v. Baton Rouge Railcar Serv., 526 So. 2d 824 (La. App. 1st Cir.), writs denied, 530 So. 2d 84, 87, 89 (1988).

an uninsured or underinsured motor vehicle. Generally, the policy definition of the uninsured motor vehicle excludes a vehicle owned by a qualified self-insurer.[10] The validity of this policy provision was challenged in *Jones v. Henry*.[11] The plaintiffs were allegedly injured as a result of the negligence of the driver of a U-Haul truck. In compliance with Louisiana's compulsory insurance laws, U-Haul had qualified as a self-insurer in lieu of providing coverage for its vehicles under a motor vehicle liability policy.[12] The plaintiff's UM coverage with Hartford excluded coverage for a vehicle "owned or operated by a self-insurer within the meaning of any motor vehicle financial responsibility law, motor carrier law or any similar law."

While the supreme court recognized that becoming a qualified self-insurer is one means of complying with the compulsory insurance law, the court noted that the UM statute[13] does not contain any exception for qualified self-insurers. It concluded that the UM statute and the underlying public policy require that UM coverage be applicable unless the responsible parties are adequately covered by a liability insurance policy. The court indicated that the UM carrier should bear the risk of insolvency of the self-insurer, subject to the right of the UM carrier to seek reimbursement from the self-insurer upon payment of the claim.[14]

A footnote in *Jones* contained interesting dictum on the issue of whether a qualified self-insurer is required to provide UM protection for the occupants of its vehicle. The court observed that the UM statute

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10. For example, the Personal Auto Policy drafted by Insurance Services Office and used by many insurers contains the following:

> However, "uninsured motor vehicle" does not include any vehicle or equipment:
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> . . .
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> Owned or operated by a self-insurer under any applicable motor vehicle law . . .

11. 542 So. 2d 507 (La. 1989).

12. See La. R.S. 32:861-865 (1989).

13. La. R.S. 22:1406(D) (1982 & Supp. 1989).

14. In a series of decisions, the supreme court has recognized that the UM insured may compromise with and release the tortfeasor and his liability insurer, thus preventing further action by the UM insurer against the tortfeasor for reimbursement. Bosch v. Cummings, 520 So. 2d 721 (La. 1988); Pace v. Cage, 419 So. 2d 443 (La. 1982); Bond v. Commercial Union Assur. Co., 407 So. 2d 401 (La. 1981); Niemann v. Travelers Ins. Co., 368 So. 2d 1003 (La. 1979). There does not appear to be anything in the rationale for these decisions that would prevent the applicability of the rule to a qualified self-insurer. Thus, it would appear that a UM insured could settle with and release a qualified self-insurer and still pursue a claim against his UM carrier. Such a release would seem to preclude further claims for reimbursement by the UM carrier.

What credit against the total damages would the UM carrier receive from the insured's settlement with the self-insurer? Presumably, the UM carrier would be entitled to credit for at least the full amount paid by the self-insurer. Upon showing that the settlement was for less than reasonable amount with a solvent self-insurer, perhaps the UM carrier should receive greater credit.

and the compulsory security law, "when read together, lead to no other conclusion except that there must be a policy of insurance in effect in order to trigger the requirement of UM coverage."[15] Because the issue was not before the court, however, the court stated that it would not express an opinion concerning whether such an arrangement contravened the public policy underlying the UM statute.[16]

JUDICIAL INTEREST

Liability Insurance

Recent decisions indicate some confusion concerning the responsibility of a liability insurer for the payment of judicial interest. Louisiana Revised Statutes 13:4203 provides that legal interest on all judgments, "sounding in damages, 'ex delicto,'" shall be due from the date of judicial demand. Louisiana Civil Code article 2924, as amended effective January 1, 1988, provides for an annually adjusted interest rate. Liability insurance policies commonly provide for the payment of judicial interest as a supplementary benefit to the policy limits for bodily injury and property damage. For example, a typical supplementary payments provision requires the insurer to pay:

> all interest on the entire amount of any judgment therein which accrues after entry of the judgment and before the company has paid or tendered or deposited in court that part of the judgment which does not exceed the limit of the company's liability thereon.[17]

Notwithstanding such policy language under which the insurer assumes the obligation for interest only from entry of judgment, the Louisiana Supreme Court in *Soprano v. State Farm Mutual Automobile Insurance Co.*,[18] held that the insurer, under the provisions of Louisiana Revised Statutes 13:4203, is liable for pre-judgment interest on its policy limits from the date of judicial demand. More recently, in *Burton v.*

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15. 542 So. 2d at 510.

16. Several cases have found that a qualified self-insurer was not required to provide UM protection. Hebert v. Williams, 526 So. 2d 835 (La. App. 3d Cir.), writ denied, 532 So. 2d 150 (1988) (lessee, as qualified self-insurer, was not required to provide UM coverage to the occupants of leased vehicles); Harrison v. Petri, 468 So. 2d 666 (La. App. 4th Cir. 1985) (self-insured with excess coverage is not required to provided UM protection within the self-insured's retained limit); Jordan v. Honea, 407 So. 2d 503 (La. App. 1st Cir. 1981), writ denied, 409 So. 2d 654 (1982).

17. See Doty v. Central Mutual Ins. Co., 186 So. 2d 328 (La. App. 3d Cir.), writ denied, 249 La. 486, 187 So. 2d 451 (1966).

18. 246 La. 524, 165 So. 2d 308 (1964).

Foret,[19] the supreme court held that legal interest under Louisiana Revised Statutes 13:4203 accrues from the date judicial demand is made against any solidary obligor. Thus, interest commences to run against the insurer from the date of judicial demand against the tortfeasor even though the liability insurer or the UM carrier is not joined in the action until a later date.

Doty v. Central Mutual Insurance Co.[20] is generally recognized as the landmark decision for the proper interpretation of the insurer's obligations to pay interest under the statute and under the supplemental payments provision of the insurance policy. The insured was held liable for damages in the amount of $25,000 in solido with the insurer for its policy limits of $10,000. The insurance policy contained the supplemental payments provision quoted above requiring the insurer to pay interest on the entire amount of the judgment that accrued after entry of the judgment. The court held that the insurer, under Louisiana Revised Statutes 13:4203, was liable for interest on the amount of its policy limits of $10,000 from date of judicial demand. With respect to the $15,000 award in excess of the $10,000 policy limits, the insurer, under the supplementary payments provision, was obligated to pay interest only from the date of entry of the judgment.

While *Doty* has been applied correctly in some recent cases,[21] other cases purporting to follow *Doty* have mistakenly cast the insurer with legal interest on the full amount of the judgment from date of judicial demand.[22]

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19. 498 So. 2d 706 (La. 1986).

20. 186 So. 2d 328 (La. App. 3d Cir.), writ denied; 249 La. 486, 187 So. 2d 451 (1966).

21. Fletcher v. Leader Nat'l Ins. Co., 513 So. 2d 1226 (La. App. 4th Cir. 1987) (simplified policy form); Levet v. Calais & Sons, Inc., 514 So. 2d 153 (La. App. 5th Cir. 1987). See also Smith v. Zale Indem. Co., 538 So. 2d 1142 (La. App. 5th Cir. 1989). The *Zale* policy provided:

> If we decide that the award was a mistake, we will pay the costs to appeal to a higher court, including interest on the award plus the cost of any bond that may be required.

Even though it did not tender its policy limits until almost two years after judgment, *Zale* was held liable only for interest on its policy limit from date of judicial demand because it had not appealed. The court held that *Zale* was not liable for interest on the entire amount of the judgment, after entry of judgment, because the policy provision differed from the supplementary payments provision in the *Doty* case.

22. While stating that they are following *Doty*, courts in two recent cases cast insurer for interest on the full amount of the judgment from date of judicial demand. Petry v. Richard, 532 So. 2d 286 (La. App. 3d Cir.), writ denied, 533 So. 2d 382 (1988); Fowler v. Roberts, 526 So. 2d 266 (La. App. 2d Cir.), writ granted, 531 So. 2d 257 (1988), writ denied, 531 So. 2d 278 (1988) (writ applications involved other issues). The court in Hellmers v. Department of Transp. & Dev., 503 So. 2d 174, 180 (La. App. 4th Cir.),

Under the supplementary payments provision quoted above, the insurer's obligation for interest on the entire amount of the judgment after entry of the judgment terminates upon the payment, tender, or deposit of the insurer's limit of liability.[23] The tender must be unconditional[24] and in an amount sufficient to pay the policy limits plus accrued interest on the policy limits.[25]

First Party Claims

In the en banc decision of the first circuit in *River Road Construction, Inc. v. Canal Indemnity Co.*,[26] the court held that judicial interest on a first party claim accrues from the date upon which payment is due the insured under the statute regulating payment of insurance claims. This case involved recovery under an insurance policy for damage to a crane. Under Louisiana Revised Statutes 22:658, payment was due within sixty days after submission of a satisfactory proof of loss.[27] Rejecting the insurer's argument that interest ran only from date of judgment, the court held that interest ran from the date payment was due, which was sixty days after submission of a satisfactory proof of loss.

Uninsured Motorist Claims

It has been held that judicial interest on UM claims is due from date of judicial demand on the UM carrier[28] or earlier demand on a solidary obligor.[29] Since the payment of UM claims is regulated by Louisiana Revised Statutes 22:658,[30] it could be argued under *River Road*

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writs denied, 505 So. 2d 1141, 1149 (1987), held that the insured and insurer are solidarily liable for all interest, observing that "[i]t is not the function of the trial court to apportion the award between solidary defendants." Since the insurer is the solidary obligor of the insured only up to the insurer's policy limits, the insurer should not be cast for judicial interest on any amount in excess of its policy limits except to the extent that it expressly assumes the obligation for the payment of such interest under its policy.

23. The expense of delay is illustrated by Dobson v. Aetna Casualty & Sur. Co., 484 So. 2d 976 (La. App. 3d Cir. 1986). The insured, with liability limits of only $5,000, was held liable for approximately $620,000. The insurer's six month delay after entry of the judgment in tendering its $5,000 policy limits cost the insurer over $30,000 in judicial interest.

24. Tippett v. Maryland Cas. Co., 536 So. 2d 694 (La. App. 3d Cir. 1988); Petry v. Richard, 532 So. 2d 286 (La. App. 3d Cir. 1988).

25. Hartford Accident & Indem. Co. v. United General Ins., 855 F.2d 228 (5th Cir. 1988).

26. 538 So. 2d 625 (La. App. 1st Cir. 1988).

27. La. R.S. 22:658 (Supp. 1989) was amended to reduce the time period to thirty days by 1989 La. Acts No. 638.

28. Ainsworth v. Government Employees Ins. Co., 433 So. 2d 709 (La. 1983).

29. Burton v. Foret, 498 So. 2d 706 (La. 1986).

30. McDill v. Utica Mut. Ins. Co., 475 So. 2d 1085 (La. 1985); Hart v. Allstate Ins. Co., 437 So. 2d 823 (La. 1983).

that interest should commence upon expiration of the payment delay after submission of satisfactory proof of loss.

A first circuit decision misapplied the liability insurance jurisprudence and concluded that the UM carrier was liable for legal interest on the full amount of the judgment—even the amount in excess of its UM policy limits.[31] There does not appear to be any justifiable basis for casting the UM insurer with legal interest on any amount other than the amount of the judgment rendered against the UM carrier.

LIFE INSURANCE

There were no startling developments during this term in the life insurance field, but there are three decisions that deserve a very brief comment.

Defense of Intoxication

Louisiana law permits a health and accident insurance policy (which may contain accidental death benefits) to contain an exclusion of coverage if the loss is sustained "in consequence of the insured's being intoxicated" at the time of the loss.[32] There are surprisingly few cases reported at the appellate level in which policy provisions based upon this statutory authority have been interpreted. In one case decided in 1969, recovery was denied when the insured died in a one-car accident that occurred when his motor vehicle failed to negotiate a curve; his blood alcohol content was 0.29%.[33]

During this term, an appellate court reversed the trial court and permitted recovery under the accidental death portion of a health and accident policy, concluding that the insurer had not discharged its burden of proving that the injury and subsequent death were caused by intoxication.[34]

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31. Brown v. Southern Farm Bureau Ins. Co., 426 So. 2d 684 (La. App. 1st Cir. 1982). In holding the UM insurer liable for legal interest on the full amount of the judgment, not just its policy limits, from date of judicial demand until paid, the court cited O'Donnell v. Fidelity Gen. Ins. Co., 344 So. 2d 91 (La. App. 2d Cir. 1977). However, *O'Donnell*, a liability case, correctly stated and applied the *Doty* rule:

> The statute [La. R.S. 13:4203] does not, however, require an insurer to pay legal interest on any amount beyond its policy limits or on the amount of the judgment against it. Accordingly, numerous cases hold that an insurer is liable for legal interest from judicial demand only on the amount of the judgment against the insurer and not on the amount of any excess judgment against the insured.

Id. at 93.

32. La. R.S. 22:213(B)(10) (1982).

33. Matthews v. All American Assurance Co., 226 So. 2d 181 (La. App. 3d Cir.), writ refused, 254 La. 923, 228 So. 2d 483 (1969).

34. Moore v. Central American Life Ins. Co., 535 So. 2d 773 (La. App. 2d Cir. 1988).

The decedent was described as an "emaciated" lady, fifty-one years of age and weighing only ninety pounds. She seemed to have had a number of serious medical problems in her life, and it seems fair to conclude from the facts that there was some evidence of an alcohol problem in her past. On the day in question, she was in a supermarket when she fell, striking her head on a shelf. She was promptly admitted to a hospital, and transferred to another, but died the next day of extensive intracerebral hemorrhaging. A blood alcohol determination of 0.09% was obtained, but the precise time that the blood was drawn could not be determined.

The policy provided that there was no coverage for "death or injury to the insured caused . . . (3) while the insured is under the influence of intoxicating beverages . . . ." The trial court had held that the death satisfied other policy requirements as to its accidental nature, but that the intoxication exclusion defeated recovery. The appellate court took a different view, concluding that the insurer had not discharged its burden of proof, either as to intoxication or causation.

The appellate court placed great significance on the lack of specificity with respect to the time the blood sample was drawn, but it would appear that the blood alcohol content could only have gone down over time. Thus the 0.09% finding should certainly have been less than, or equal to, the content at the time of the injury. The appellate court was more appropriately concerned with the lack of testimony about how that level would affect a person's ability to function, but once again the frail nature of the decedent's body would appear to indicate that she might have been impaired even by this relatively small amount of alcohol. And finally, the appellate court noted the testimony of eye witnesses, who generally concluded that they could not tell whether the decedent was intoxicated or simply ill on the day in question.

Assuming for the sake of argument that the defendant had discharged its burden of proof on the intoxication issue, the appellate court then concluded that it had not established that the fall was due to the intoxication. This would be a difficult burden in any event, and the lack of any eye witnesses to the fall itself did not help the defendant's case.

This should probably have been a close case, and it appears that the defendant did a reasonable job of discharging its burden. Perhaps the very small face amount of the policy ($5,000.00) permitted the appellate court to be more lenient toward the plaintiff's claim for death benefits than would otherwise have been the case.

Misrepresentation

Another case must be added to the fairly long list of unsuccessful defenses by an insurer on the issue of material misrepresentation. During

this term, in *Swain v. Life Insurance Co. of Louisiana*,[35] the court was faced with a claim for recovery under a credit life policy by the spouse of a man who contracted lung cancer and died very shortly after the inception of the policy. By all accounts, he had not been in particularly good health in the years preceding the policy in question, and indeed had appeared on crutches at the car dealership at which the credit life policy was sold. But he was never asked anything about his health problems by the agent who sold the policy.

The trial court had denied recovery, but the appellate court dutifully cited the jurisprudential amendment[36] of the material misrepresentation statute[37] requiring the insurer to prove both an actual intent to deceive and a material effect on the risk by the misrepresentation. The court noted that the agent prepared the application and the policy, and did not ask the insured any questions. Since the insured was never asked to read the application form or fill in the information, the insurer failed to discharge his burden of proving that the insured could have had the intent to deceive necessary to justify a denial of coverage. The insurer's arguments based on the "sound health" clause and the presence of a pre-existing condition, both common assertions in health and accident policies,[38] were likewise unavailing.

Exclusion for Death Resulting from Inhalation of Gas or Fumes

The extreme difficulty that a life insurer has in upholding certain exclusions was demonstrated once again during this term in *Capital Bank & Trust v. Equitable Life*.[39] The insured was the owner of a business and was found dead in the building following a fire. Only days before, he and his wife had filed for bankruptcy, and it seemed apparent that either he or someone else had intentionally set fire to the establishment on the day in question. Following an autopsy, the immediate cause of death was given as asphyxiation, secondary to inhalation of toxic urethane smoke and fire and the burns due to the fire. It was stipulated that the coroner would testify that the probable cause of death was smoke inhalation.

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35. 537 So. 2d 1297 (La. App. 2d Cir.), writ denied, 541 So. 2d 895 (1989).

36. This judicial amendment process began with Gay v. United Benefit Life Ins. Co., 233 La. 226, 96 So. 2d 497 (1957). See generally W. McKenzie & H. Johnson, Insurance Law and Practice, § 257 in 15 Louisiana Civil Law Treatise (1986 & Supp. 1989) [hereinafter McKenzie & Johnson].

37. La. R.S. 22:619 (1982), which states these requirements in the disjunctive (either intent to deceive or material effect on the risk), while the decisions state them in the conjunctive (both must be proven).

38. See McKenzie & Johnson, supra note 36, § 291.

39. 542 So. 2d 494 (La. 1989). Due to the original plaintiff's insolvency, the Federal Deposit Insurance Corporation had been substituted as a plaintiff on three insurance policies which had been assigned to the bank as collateral for a loan.

The policy in question excluded coverage for death resulting from "any drug, poison, gas or fumes, voluntarily or involuntarily taken, administered, absorbed or inhaled . . . ." In a concurrence, Justice Lemmon observed that the most likely reason for the exclusion was to deny coverage for suicide. Since it had been stipulated that the death was not a homicide or a suicide, and since the term "fumes" would not necessarily include inhalation of smoke, an interpretation of that ambiguity in favor of coverage was appropriate. That would be particularly true, in his view, when the exclusion was not primarily aimed at accidental death by fire, but at assisting the insurer in proving the difficult defense of suicide. Seen from this standpoint, the decision in favor of coverage was probably unremarkable. But the majority opinion preferred the rationale that "fumes" could not mean smoke, but rather meant other forms of emissions, and thus the exclusion was inapplicable. The basic distinction between "smoke" on the one hand and "fumes" on the other is elusive at best, and it totally escaped the two dissenting justices, who found all of this to be more hair-splitting than could be justified.[40]

This opinion only confirms what most insurers already knew: suicide exclusions are very difficult to enforce. It turns out that they are especially difficult to enforce when there is no suicide.

HEALTH AND ACCIDENT INSURANCE

Jurisprudence

The maturing of *Cataldie*[41] continues. In 1984, on the basis of a very difficult factual situation, the supreme court held in *Cataldie v. Louisiana Health Service & Indemnity Co.* that the cancellation of an individual health and accident policy had been prejudicial to existing claims of an insured, and required reinstatement of the policy.[42] Over the ensuing years, the decision was subjected to a number of refinements, extensions, and contractions, not the least of which was its extension to group policies under certain circumstances.[43]

This term has been no exception, and there was an additional interesting discussion in one of the cases about the role of the Employee

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40. See id. at 498 (Marcus and Dixon, JJ., dissenting).

41. 456 So. 2d 1373 (La. 1984).

42. See generally McKenzie & Johnson, supra note 36, § 286 (especially pp. 534-36 and the pocket part discussions).

43. See McKenzie and Johnson, Insurance, Developments in the Law, 1987-1988, 49 La. L. Rev. 349, 362-63 (1988); McKenzie and Johnson, Insurance, Developments in the Law, 1986-1987, 48 La. L. Rev. 293, 300-02 (1987); McKenzie and Johnson, Insurance, Developments in the Law, 1984-1985, 46 La. L. Rev. 475, 484-88 (1986).

Retirement Income Security Act of 1974 (ERISA)[44] in the application of state law to certain insurance claims.

Two of the three decisions of note tilled some rather familiar ground. In *Guidry v. Shelter Insurance Co.*,[45] the plaintiff had purchased an individual health insurance policy providing coverage for himself and his family. The policy was renewable by the "timely payment of each premium" monthly as it became due. The policy was in force when the plaintiff was injured in an automobile accident, and the insurer paid various medical expenses as they accrued. Unfortunately, due to his injuries, plaintiff could not return to his employment and eventually could not pay the premiums on the policy. On December 24, 1983 (about six months after his injury), the policy lapsed by its own terms for non-payment of premiums.

However, the policy also provided for "continuous loss" coverage, even upon lapse, for charges for the same or related causes that occurred during the policy period. The "continuous loss" provision, however, extended only until the end of the "benefit period" under the policy, which happened to be January 1, 1984. Under that provision, the insurer paid the expenses incurred as a result of the automobile accident until January 1, 1984, but declined to pay any other benefits.

Plaintiff's suit for reimbursement of medical expenses arising from the automobile accident and incurred after January 1, 1984 was met by a motion for summary judgment by the insurer. The motion was denied, and the insurer sought relief from the appellate court by writ. The writ was granted; the motion was granted; and plaintiff's suit was dismissed.

The appellate court properly made the distinction between cancellation of the policy and termination of the policy.[46] Cancellation refers to the unilateral action of the insurer which ends coverage, with or without cause, prior to the scheduled termination date of coverage; typically, the term has also included the end of coverage on the basis of non-payment of premiums. On the other hand, termination is the ending of coverage on the basis of an event anticipated by, and governed by, the terms of the policy itself, such as termination of employment under a group policy.[47] Since the appellate court saw the instant matter as one of termination rather than cancellation, it properly rejected plaintiff's reliance upon the cancellation cases such as *Cataldie*.[48] The

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44. 29 U.S.C. §§ 1001-1461 (1982 & Supp. III 1985).

45. 535 So. 2d 393 (La. App. 3d Cir. 1988).

46. See generally McKenzie & Johnson, supra note 36, §§ 226 and 286.

47. See Mezzacappo v. Travelers Ins. Co., 523 So. 2d 291, 294 (La. App. 3d Cir.), writ denied, 531 So. 2d 473 (1988).

48. To be perfectly accurate, there was perhaps a "termination" in *Cataldie*, or perhaps unilateral action by the insured to cease coverage, but it was deemed by the

court held that the policy provisions relative to termination were clear and unambiguous, and could be enforced as written.

In *Perkins v. Shelter Insurance Co.*,[49] a group health and accident policy insured employees of an automobile dealership and their dependents. Premiums were paid on a fifty-fifty basis by the employer and the employee. The employer paid the full premium in advance for any given month, and then collected the employee's contribution out of his paychecks during that ensuing month. The employer paid the full premium in advance for the month of May, 1983, but the employee in question was terminated before the end of that month. Thereafter, no further payments were made on behalf of that employee, and specifically no payment was made for the month of June, 1983.

On June 9, 1983, the employee's nineteen-year-old daughter was injured in an automobile accident. On the basis of the termination of employment in late May, 1983, and the lack of any premium for the month of June, 1983, the insurer denied coverage and the employee filed suit. The trial court granted relief, but the appellate court reversed. Once again, the court properly recited the difference between cancellation and termination. Finding that this was a termination under the provisions of the policy rather than a cancellation, the court held that the statute that sanctions lack of notice of a cancellation was inapplicable.

In this instance, the policy specifically provided that upon cessation of the employment relationship, coverage under the policy terminated, absent special circumstances not present in the instant case. The court further noted that the employee had a right to convert his policy from a group basis to an individual basis upon his severance from the employer's payroll, but chose not to do so.

The decision in *Soniat v. Travelers Insurance Co.*[50] addresses the cancellation/termination issue in a much more appealing factual situation for the claimant. This time, a group health insurance policy had been cancelled for non-payment of premiums, but the employer had collected the premiums from the employee and failed to forward them to the plan administrator and the insurer. Very shortly thereafter, the policy was cancelled due to non-payment of premiums, and the employer went out of business in May, 1984.

The employee's spouse was pregnant, and her time was fulfilled on June 22, 1984. At the inception of the pregnancy, the insurance was in full force and effect. By the time of the birth, all of the foregoing

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supreme court to be a "cancellation" (and to be treated as such) because the insurer had escalated the premiums to the point that the insured could no longer afford sufficient coverage.

49. 540 So. 2d 488 (La. App. 1st Cir. 1989).

50. 538 So. 2d 210 (La. 1989).

events had occurred. When the insurer declined to pay for the expenses of the delivery, the claimant brought suit. The trial court had granted recovery, but the appellate court reversed on the strength of a policy provision that fixed the last day of the month in which the employment terminated as the last possible date of coverage. Since the baby was born three weeks after May 31, 1984, the appellate court ruled that there was no coverage.

The appellate court saw the matter as one of termination rather than cancellation, and thus pretermitted the issue of lack of written notice of cancellation.[51] The supreme court disagreed. It held that the policy had been *cancelled* for non-payment of premiums before the employee's work relationship was terminated. Accordingly, it held that *Cataldie* governed the case and that the cancellation with respect to a covered dependent who was eight months pregnant was prejudicial to the insured. Thus it reinstated the trial court's judgment in favor of the insured, though it denied penalties awarded by the trial court. The award of attorney's fees, however, was affirmed on federal law grounds rather than the state law grounds awarded by the trial court.

One other aspect of the decision is important. As a threshold matter, the supreme court had to determine whether ERISA pre-empted the provision of state law governing cancellation without prejudice, which was the basis for the decision in *Cataldie* and which would be the basis for the plaintiffs' recovery in *Soniat*. Analyzing *Pilot Life Insurance Co. v. Dedeaux*,[52] the supreme court held that the provisions of the Insurance Code governing permissible provisions in group health and accident policies were clearly specific to the insurance industry and thus fell within the "saving" clause of ERISA which preserves such state regulation of the insurance industry.[53] The court noted that the remedies which the Soniats sought, unlike those sought by the claimant in *Pilot Life*, were not generally available in other Louisiana contract cases, and thus should be considered squarely within state regulation of insurance matters.

The rationale of the court's decision in *Soniat* on the ERISA issue should be studied carefully for its future influence on the pre-emption issue in other cases.

Legislation

Most of the legislative attention paid to the insurance industry during this term focused on the field of health and accident insurance. As a further legislative refinement on the *Cataldie* problem, one act requires

51. See Soniat v. Travelers Ins. Co., 517 So. 2d 325 (La. App. 1st Cir. 1987).
52. 481 U.S. 41, 107 S. Ct. 1549 (1987).
53. 29 U.S.C. § 1144(b)(2)(A) (1982).

that if a group health insurance policy is cancelled by the insurer and a covered member of the group has been diagnosed prior to the cancellation as having a terminal illness, and is not eligible for any other benefits, the insurer must offer a conversion option to a major medical policy with a maximum coverage not to exceed $1,000,000.00.[54] Another act addresses another part of the *Cataldie* problem by enacting a new standard policy provision requiring that the insurer give notice to the policyholder of non-payment of a given premium and of the grace period allowed by the policy for payment of the overdue premium.[55] The provision must also state that the policy will be reinstated without penalty if the premium is received by the end of the applicable grace period.

Act 409 continues the recent trend of statutorily-required types of coverage under health and accident policies. If a policy affords coverage for the "primary medical condition" of cleft lip and cleft palate, it must also include "secondary conditions and treatments" such as oral and facial surgery, restorative dentistry, speech therapy, audiological assessments, psychological assessments, and genetic counseling for the patient and the parents.[56] While the trend of increasing statutory requirements of coverage may be laudable in the specific case, it may prove counterproductive in the long term. If an insurer which provides basic coverage for a certain condition is made to include other "secondary" conditions as described in an enactment such as Act 409, it might decide to decline to cover the basic condition itself. Thus, a legislative effort to expand coverage might in certain instances produce a radical restriction in coverage.

Finally, the prescriptive period for claims for penalties and attorney's fees under health and accident policies was shortened to one year by Act 773.[57]

PROPERTY INSURANCE

Jurisprudence

The two decisions of note during this term in the property insurance field concern insurable interest and measure of loss in the case of movables. Neither opinion requires more than a brief comment.

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54. La. R.S. 22:228, as enacted by 1989 La. Acts No. 269, effective June 26, 1989. The premiums on the conversion policy are to be determined in accordance with the insurer's table of premium rates applicable to the age and sex of the insured.

55. La. R.S. 22:213(A)(14), as enacted by 1989 La. Acts No. 426.

56. La. R.S. 22:215.8, as enacted by 1989 La. Acts No. 409.

57. La. R.S. 22:657(E), as enacted by 1989 La. Acts No. 773. The act almost certainly has constitutional problems. It is contained in a bill which also provides a lengthy enactment regulating collision damage waivers in automobile rental contracts. It is difficult to see why the bill does not violate the constitutional requirement that each bill "shall be confined to one object." La. Const. art. III, § 15(A).

A rather loose business arrangement in *Johnson v. Midland Insurance Co.*[58] gave rise to a dispute about the existence of an insurable interest in a piece of heavy equipment. Johnson purchased a front-end loader from Miller Tractor, financing the purchase through Ford Motor Credit. Johnson procured an insurance policy from Midland covering fire and other risks, with both Ford and Miller as additional loss payees. About a year later, Johnson sold the loader to Havens. Havens paid a down payment and then made monthly payments to Johnson, who transferred them to Ford. The vendor and vendee agreed that Johnson would keep the Midland policy in force. There seemed to be little formality to the sale itself, and no assignment of the insurance policy.

The loader burned. Havens stopped payments. Johnson paid Ford and Miller the amounts due and sued to recover under the Midland policy. Midland was insolvent; Louisiana Insurance Guaranty Association (LIGA) was the successor defendant.

LIGA contended that Johnson did not have an insurable interest after the sale, and therefore could not enforce the contract.[59] The court noted that in a sale without a credit aspect, it would typically be held that the seller did not retain an insurable interest, and a policy issued to the seller might well not be enforceable.[60] But it also observed that a seller with a continuing economic interest through some kind of security has a sufficient insurable interest to permit the enforcement of the policy.[61] In this instance, even though there was no promissory note or chattel mortgage, there was probably a vendor's lien, and on that basis, the court upheld the determination that Johnson could enforce the policy.

In *Peoples Bank v. Insured Lloyds*,[62] the dispute was over the proper measure of damage in a partial loss of stored cottonseed due to fire. After an investigation, the insurer paid the difference between the value of the cottonseed before the fire and the salvage value. Because of the perishable nature of the commodity, the salvage value was estimated by an expert in such matters who had purchased the damaged commodity.

Unfortunately, the purchaser did not complete his payments for the salvaged commodity, and the bank to whom the prior owner had assigned his rights under the policy sued the insurer for the difference. Both the trial court and the appellate court concluded that the individual who arranged the sale of the damaged commodity (actually one of the three insured owners) was acting as the agent of the insurer. Moreover, both

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58. 541 So. 2d 1010 (La. App. 3d Cir. 1989).

59. La. R.S. 22:614 (1982).

60. See Union Cental Life Ins. Co. v. Harp, 203 La. 806, 14 So. 2d 643 (1943); Eagle Star Ins. Co. v. General Accident Fire & Life Assurance Corp., 315 So. 2d 826 (La. App. 3d Cir. 1975).

61. See generally McKenzie & Johnson, supra note 36, § 314.

62. 537 So. 2d 1307 (La. App. 3d Cir.), writ denied, 541 So. 2d 855 (1989).

courts concluded that the insurer actually owned the damaged commodity after the fire, and therefore should in effect suffer the loss of the non-payment rather than effectively cast it upon the insured.

This seemed clear enough, but the dissenting judge pointed out that the terms of the policy refuted this analysis.[63] In his view, which seems correct, the policy left with the *insurer*, in the case of a partial loss, the option to take ownership of the damaged property and forbade an "abandonment" of any property to the insurer.[64] Finding that the insurer had never exercised the option to take the property, the dissenting judge concluded that the property remained the insureds' and the risk of loss under the contract of sale that they entered should properly remain with them.

Legislation

Aside from a rather minor change in the standard fire policy provision as to cancellation of a policy for non-payment of premiums and notice of such cancellation,[65] the legislation relative to property and casualty insurance was easily the most important of the 1989 Regular Session of the Louisiana Legislature. Act 638 of 1989 indubitably requires more extended discussion than this space will permit. Effectively reversing the specific exemption for insurance from the Unfair Trade Practices Act that has existed for years,[66] this act defines and sanctions "unfair claims settlement practices" by insurers. The various proscribed types of conduct are too voluminous to analyze here, but suffice it to say that they run the gamut of settlement practices in very broad terms.[67] If, after a hearing before the Commissioner of Insurance, it is determined that the statute has been violated, a "monetary penalty" of not more than $1,000.00 for each violation, but no more than $10,000.00 in the aggregate, may be imposed.[68] However, if the violator "knew or reasonably should have known" he was in violation, the penalties are increased to a maximum of $5,000.00 for each violation and $50,000.00 in the aggregate "in any six-month period." The act is effective for all claims arising after midnight on December 31, 1989.

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63. Id. at 1311 (Stoker, J., dissenting).

64. This clause is within the standard form of fire policy under La. R.S. 22:691(F) (1982 & Supp. 1989).

65. 1989 La. Acts No. 657, amending La. R.S. 22:691(F), reduces the twenty-day period normally required for notice of cancellation to ten days when the cancellation is for non-payment of premiums.

66. La. R.S. 51:1406(1) (1987). See Alarcon v. Aetna Caualty and Sur. Co., 538 So. 2d 696 (La. App. 5th Cir. 1989).

67. The list is contained in La. R.S. 22:1214(14), as amended and reenacted by 1989 La. Acts No. 638.

68. La. R.S. 22:1217, as amended and reenacted by 1989 La. Acts. No. 638.

Act 638 is destined to become a very controversial part of the Insurance Code. If nothing else, it will very likely add to the number and scope of hearings by the Commissioner and his staff. It seems certain that we will hear much more about it in the coming years.