



# THE HIDDEN CONFLICT: THE SECRET INSURERS DON'T TELL INSUREDS

Michael Childress and Daniel Loucks

## I. INTRODUCTION<sup>1</sup>

The insurance industry operated for centuries under certain fundamental principles. An insured, looking to minimize its own risk, looks to purchase an insurance policy. The insurer issues the policy and remains profitable by spreading risks over as large a population as possible. In the event of a loss, the insurer and insured give effect to the policy terms. In recent years, however, insurers have employed a cornucopia of cost saving tactics that have turned this elementary understanding of the insurance process on its head. Brokers work to benefit the insurance industry while insurers analyze risk only after issuing policies and shift that risk back onto the insureds. The supposed camaraderie and commonality of interest touted by insurers gives way to an increasingly adversarial process that treats the insured as a foe. Following a loss, insurers lowball and coerce

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<sup>1</sup> Michael L. Childress is a founding shareholder of Childress Duffy, Ltd., a law firm with extensive experience in helping insurance policyholders with their claims. Since 1981, he has negotiated, adjusted, and prosecuted insurance claims arising in forty states, successfully coordinating thousands of investigations, and worked with experts from many fields. Much of the information within this article comes from his extensive experience representing national and international policyholders in matters that involve risk management, disaster recovery, and insurance coverage. We have noted in corresponding footnotes those instances where a statement is made based on his experience.

vulnerable insureds into signing releases and waivers. Insurers cry wolf following a natural disaster and claim that bankruptcy is inevitable if they are compelled to pay claims on a large scale.

Highlighted by recent natural catastrophes such as Superstorm Sandy and the series of earthquakes in Christchurch, New Zealand, the insurance industry is in desperate need of reform. Governments across the world have attempted to step in and provide relief for the insureds, and individual states in the United States have promulgated statutes aimed at disincentivizing such insurer conduct. These answers have been met with varying success.

## II. DISASTER BACKGROUND

Natural disasters are occurring with increased frequency. Nine hundred natural catastrophes caused \$160 billion in overall loss worldwide in 2012,<sup>2</sup> and 2011 saw 820 catastrophes cause \$400 billion in overall loss.<sup>3</sup> Compared to the thirty year average, which included 650 events and \$115 billion in overall loss, natural disasters have also become more destructive.<sup>4</sup> Eight of the ten costliest natural catastrophes since 1950 occurred in 2004 or later, and none occurred prior to 1992.<sup>5</sup> Violent hurricanes continue to hit the United States;<sup>6</sup> New Zealand has suffered a series of earthquakes;<sup>7</sup> and Australia has

<sup>2</sup> *Catastrophes: Global, INS. INFO. INST.*, [http://www.iii.org/facts\\_statistics/catastrophes-global.html](http://www.iii.org/facts_statistics/catastrophes-global.html) (last visited Nov. 6, 2013).

<sup>3</sup> *Id.*

<sup>4</sup> *Id.* The thirty year average spans from 1982–2011. *See id.*

<sup>5</sup> MUNICH REINSURANCE AM., INC., 2011 HALF-YEAR NATURAL CATASTROPHE REVIEW 35 (2011), *available at* [http://www.climateneeds.umd.edu/reports/MunicRe\\_III-2011\\_HalfYear\\_NatCat\\_Review.pdf](http://www.climateneeds.umd.edu/reports/MunicRe_III-2011_HalfYear_NatCat_Review.pdf). Catastrophes are ranked by insured loss, not total loss. *See id.*

<sup>6</sup> *Hurricane Archive, WEATHER UNDERGROUND*, <http://www.wunderground.com/hurricane/hurrarchive.asp> (last visited Nov. 19, 2013).

<sup>7</sup> *Recent Earthquakes That May Have Been Felt in the New Zealand Region Over the Past Year*, GEONET, <http://www.geonet.org.nz/quakes/felt/severe> (last visited Nov. 19, 2013).

experienced bushfires spanning five states,<sup>8</sup> a “major flood crisis” in Queensland,<sup>9</sup> and a cyclone.<sup>10</sup>

And yet the insurance industry is thriving. Insurance premiums represented 8.1% of the United States’ GDP in 2011.<sup>11</sup> The first three quarters of 2012<sup>12</sup> saw U.S. property and casualty insurers enjoy a dramatic post-tax net income increase, rising by 221.7% to \$27 billion.<sup>13</sup> Over the same period insurers’ underwriting losses tumbled 81% to \$6.7 billion, while premiums grew 4.2%.<sup>14</sup> Australian insurers earned \$21.33 billion and averaged a net loss ratio of 65.33% in the first three quarters of 2012.<sup>15</sup> Between July 2011 and June 2012, Australian homeowner insurers received \$66 million in

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<sup>8</sup> *Bushfire Threat Remains Across Five States*, THE AUSTRALIAN (Jan. 12, 2013), <http://www.theaustralian.com.au/news/nation/nsw-act-and-tas-travellers-residents-warned-to-monitor-fire-alerts/story-e6frg6nf-1226552505417>.

<sup>9</sup> Nick Bryant, ‘Major Flood Crisis’ Hits Queensland, Australia, BBC NEWS (Jan. 28, 2013, 9:33 AM), <http://www.bbc.co.uk/news/world-asia-21226178>.

<sup>10</sup> Adam Gabbatt, *Cyclone Yasi Strikes North Queensland*, THE GUARDIAN (Feb. 2, 2011, 1:49 PM), <http://www.guardian.co.uk/world/2011/feb/02/cyclone-yasi-north-queensland>.

<sup>11</sup> INS. INFO. INST., INTERNATIONAL INSURANCE FACT BOOK 2013 3 (2013), available at [http://www2.iii.org/assets/docs/pdf/International\\_Insurance\\_Factbook\\_2013.pdf](http://www2.iii.org/assets/docs/pdf/International_Insurance_Factbook_2013.pdf).

<sup>12</sup> Superstorm Sandy hit the east coast in October, 2012, and as such is not included in this calculation. For reference, Sandy-related claims are currently estimated at \$19 billion. See *Likely to Be Third Largest Storm Ever for U.S. Insurers*, INS. INFO. INST., [http://www.iii.org/press\\_releases/over-90-percent-of-the-new-jersey-and-new-york-sandy-insurance-claims-have-been-settled-likely-to-be-third-largest-hurricane-ever-for-us-insurers.html](http://www.iii.org/press_releases/over-90-percent-of-the-new-jersey-and-new-york-sandy-insurance-claims-have-been-settled-likely-to-be-third-largest-hurricane-ever-for-us-insurers.html) (last visited Nov. 19, 2013).

<sup>13</sup> Robert Hartwig, *2012 – First Nine Months Results*, INS. INFO. INST. (Dec. 28, 2012), <http://www.iii.org/articles/2012-first-nine-months-results.html>.

<sup>14</sup> *Id.*

<sup>15</sup> AUSTL. PRUDENTIAL REGULATION AUTH., KEY GENERAL INSURANCE INDUSTRY STATISTICS, available at <http://www.insurancecouncil.com.au/industry-statistics-data/gi-statistics> (last visited Nov. 7, 2013).

premiums and paid only \$29 million in claims.<sup>16</sup> New Zealand insurers had loss ratios of 55.65% and 62.30% for material damage and business interruption policies and domestic buildings and contents policies, respectively.<sup>17</sup> The parent company of Vero Insurance, one of the biggest property insurers in Australia and New Zealand, saw its stock outperform the ASX 200<sup>18</sup> index “despite five years of disaster recoveries.”<sup>19</sup>

### III. INSURANCE BACKGROUND

The concept of insurance is not new or novel.

In ancient times, farmers of China sent their crops to market on boats. Inevitably, on occasion a boat sank along the way. The farmers began spreading their crops among numerous boats, so that if one boat sank, any one family would only lose a small portion of their crops, thus avoiding financial devastation. The loss was spread among many families, and was therefore manageable for each one.

Actual insurance contracts originated in the 13th century with ship owners who wanted to protect themselves against the possibility of catastrophic losses. As before, ships were inevitably lost at sea from time to time. The owners were aware of this, but they could not foresee which ships would be lost at what time. Wealthy individuals agreed to

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<sup>16</sup> AUSTL. PRUDENTIAL REG. AUTH., GENERAL INSURANCE SUPPLEMENTARY STATISTICAL TABLES 11 (2012), available at <http://www.apra.gov.au/GI/Publications/Documents/GI%20Supplementary%20Statistical%20Tables%202012-%2006.pdf>.

<sup>17</sup> *Industry Data*, Ins. Council N.Z., <http://icnz.org.nz/statistics-data/general-insurance/> (last visited Nov. 10, 2013). Statistics do not include earthquake claims. See *id.*

<sup>18</sup> The ASX 200 index is an Australian stock market index.

<sup>19</sup> Tamsyn Parker, *Christchurch Backlash Predicted for Big Insurers*, N.Z. HERALD (Aug. 14, 2012, 5:30 AM), [http://www.nzherald.co.nz/christchurch-earthquake/news/article.cfm?c\\_id=1502981&objectid=10826723](http://www.nzherald.co.nz/christchurch-earthquake/news/article.cfm?c_id=1502981&objectid=10826723).

receive a certain amount of money from each ship owner in exchange for a promise to pay for the loss of a ship when it occurred. Insurance is, in actuality, a social vehicle for spreading the *risk* of financial loss among a large group of people, thus making a loss manageable for any one person of that group.<sup>20</sup>

The purpose of insurance is to restore the insured to their original financial position.<sup>21</sup> Over the years, its basic premise remains unchanged: to spread risk, thus making loss, when it occurs, manageable.<sup>22</sup> Moreover, the purpose of the Unfair Claims Settlement Practices Model Act (1972) is to set forth standards for the investigation and disposition of claims.<sup>23</sup> Through implied good faith, this Act requires insurance companies to promptly investigate claims and settle claims arising under its policies.<sup>24</sup> Claims cannot be denied before a reasonable investigation has been conducted.<sup>25</sup> Settlement of claims must be prompt, fair, and equitable when the insurer's liability has become reasonably clear.<sup>26</sup>

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<sup>20</sup> *History of Insurance*, FIN. WEB, <http://www.finweb.com/insurance/history-of-insurance.html#axzz2koyLjaX7> (last visited Nov. 5, 2013).

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> *NAIC/FIO Meeting on Market Conduct*, NAT'L ASS'N OF INS. COMM'R 18 (2011), available at [http://www.naic.org/documents/index\\_financial\\_reform\\_fio\\_111207\\_agenda.pdf](http://www.naic.org/documents/index_financial_reform_fio_111207_agenda.pdf).

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

## IV. TACTICS EMPLOYED BY INSURERS TO DENY OR MINIMIZE CLAIMS: HIDDEN CONFLICTS

### A. BROKER UNDERWRITING INTERFERENCE

Insureds often have no contact with the entity actually providing insurance, but instead exclusively meet with insurance brokers or agents. As such, the broker, and not the insurer, explains what the insured's policy includes and excludes and deals with the insured in the event of a loss. These brokers furthermore act under the guise of being a friend to the insured; the insured is lead to believe that the broker acts in the insured's best interest, finds the best coverage, and stands up to the insurer on behalf of the insured. Unbeknownst to the insured, however, the insurer spares no effort or expense in turning a broker into its own surrogate.<sup>27</sup>

Conflicts of interest manifest themselves in a variety of circumstances and at various times throughout the insurance process. A common misrepresentation to an insured comes from the broker promising to scour the globe searching for the most comprehensive coverage at the most reasonable price. What the insured does not know, however, is that insurers send more attractive brokers—those that minimize claims and costs—on lavish vacations in return for the broker's client list and loyalty.<sup>28</sup> Faced with such added perks, brokers often refer the insured to only one or two choice insurers.

Insurers also achieve broker loyalty by basing the broker's compensation on the insurer's loss ratio.<sup>29</sup> In essence, insurers

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<sup>27</sup> Indeed, a not insignificant amount of confusion exists concerning precisely to whom brokers and agents owe their duty. *See generally* Colin Sammon, Comment, *Insurance Agent and Broker Liability: Crossing the Two Way Street*, 29 OHIO N.U. L. REV. 237 (2002).

<sup>28</sup> Grant Robertson & Tara Perkins, *What Your Insurance Broker Doesn't Want You to Know*, THE GLOBE & MAIL (Dec. 21, 2010), <http://www.theglobeandmail.com/report-on-business/what-your-insurance-broker-doesnt-want-you-to-know/article561110/?page=all> (discussing how Canadian life insurers court brokers).

<sup>29</sup> Jeffrey Mark Wilder, *Contingency Fees and Incentives in Commercial Lines Insurance*, (Aug. 15, 2002) (unpublished Ph.D. dissertation, Massachusetts Institute of Technology) *available at* <http://hdl.handle.net/1721.1/17550>.

base a broker's compensation not only on the number of clients provided, but also on the amount the insurer pays out in claims; the more the insurer pays the insured, the less the insurer pays the broker. Such payment schemes naturally result in a strong incentive for brokers to act in their own self-interest, instead of the insured's, and keep claims and payments down and premiums up.

When a loss occurs, the brokers or agents are the first line of defense against claims. Notice of a claim must be given to the broker. The brokers will, at that point, give an opinion of coverage or worthiness of the claim.

Brokers may use a wide range of tactics to convince a policyholder to simply abandon their claim. Brokers often suggest that policyholders may face increased premiums, cancellation, or inability to find cover if they pursue their claims to scare policyholders into accepting a smaller settlement than what they are owed. The goal is to convince a policyholder that the costs of pursuing a claim will be far greater than any possible settlement. Brokers encourage policyholders to walk away from a claim in order to avoid more headaches.

This is all the more true after a widespread natural disaster. Many natural disasters include some type of water damage. A policy's coverage of water damages is often contingent on the actual source of the water.<sup>30</sup> This creates uncertainty and doubt about coverage, which brokers seize on to create doubt with insureds about whether to proceed with a claim at all.

## B. POST LOSS UNDERWRITING

In an ideal world, premiums and coverage are based on risk factors. Before issuing an insurance policy, an underwriter or agent examines the property's potential for loss and issues a policy with premiums based on the potential for loss. However, through a process known as post-loss underwriting, insurers

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<sup>30</sup> This conclusion is based on my thirty-two years of experience as a property insurance litigator.

insure a building without first examining its risk factors.<sup>31</sup> The insurer quietly collects premiums and permits the insured to operate under the assumption that the property is sufficiently insured.<sup>32</sup> In the insured's mind, any property defect would have been raised by the insurer or broker and attended to in the policy. However, in such a situation it is only *after* a loss occurs that the insurer finally gets around to analyzing the risk, at which point the insurer knows precisely what it has to exclude to minimize claims. The insurer can point to a perceived construction defect as the sole cause of the damage and deny the insured's claim, despite the defect having existed well before the insurer issued the policy. The insured could have taken appropriate action had it known at the outset that its property suffered from a construction defect, yet post-loss underwriting's tendency to lull the insured into a false sense of confidence often prevents the insured from becoming so informed.<sup>33</sup>

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<sup>31</sup> Post-loss underwriting is a particularly attractive tactic for insurers when dealing with large and infrequent losses like natural disasters. See Brian Barnes, Note, *Against Insurance Rescission*, 120 YALE L.J. 328, 339 (2010).

<sup>32</sup> *Id.*

<sup>33</sup> Post-loss underwriting is not limited to property or casualty insurance. In 1994, the Mississippi Supreme Court examined this practice in the context of an individual intensive care policy:

An insurer has an obligation to its insureds to do its underwriting at the time a policy application is made, not after a claim is filed. It is patently unfair for a claimant to obtain a policy, pay his premiums and operate under the assumption that he is insured against a specified risk, only to learn *after* he submits a claim that he is *not* insured, and, therefore, cannot obtain any other policy to cover the loss. The insurer controls when the underwriting occurs. It therefore should be estopped from determining whether to accept an insured six months or more after a policy is issued. If the insured is not an acceptable risk, the application should be denied [sic] up front, not after a policy is issued. This allows the proposed insured to seek other coverage with another company since no company will insure an individual who has suffered serious illness or injury.

Lewis v. Equity Nat'l Life Ins. Co., 637 So. 2d 183, 188–89 (Miss. 1994) (emphasis in original).



## C. CLAIMS HANDLING PRACTICES: SHIFTING RISK BACK ONTO THE INSURED

An insurer has but two basic obligations. First, the insurer must provide services, the least of which encompasses conducting a reasonable investigation following a loss. Second, the insurer must pay claims pursuant to the policy. And yet, with increasing frequency insurers are conducting superficial investigations or forcing the insured to bear the cost of the investigation,<sup>34</sup> whether directly—by demanding the insured pay the costs<sup>35</sup>—or indirectly—“through broad information requests propounded upon the insured as part of a ‘claims’ investigation”<sup>36</sup>.

### 1. Running and Gunning

Following a publicized calamity such as a hurricane or earthquake, insurance companies are eager to acquire some positive media coverage. After all, video of newly-homeless hurricane victims whose insurer refuses to pay a claim can hardly be good for business. Insurers attempt to avoid this negative PR by engaging in a practice known as “running and gunning,” under which an unqualified adjuster slaps a Band-Aid on the damage and is never seen again.<sup>37</sup>

Large-scale natural disasters cause insurers to suffer somewhat understandable headaches. The insurer’s chief goal in these situations is to cut down on the number of claims by speeding up every step of the claim procedure, regardless of what the insured is entitled to under the policy. Hundreds, if not thousands, of insureds become effectively homeless

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<sup>36</sup> Clyde M. Hettrick, *How an Insured Can Block a Carrier's Coverage Litigation Blitz*, 26 Ent. & Sports L. 9, 10 (2008).

<sup>37</sup> David B. Caruso, *Many Hurricane Sandy Victims Getting Shortchanged on Flood Insurance*, ASSOC. PRESS (Oct. 20, 2013, 12:12 PM), <http://www.dailyfinance.com/2013/10/20/hurricane-sandy-victims-shortchanged-flood-insurance/>.

overnight and the insurer needs to send claims adjusters en masse to examine the affected properties.<sup>38</sup> The demand for qualified adjusters quickly eclipses the supply, and in their haste insurers send anyone into the field that can simultaneously walk and chew gum.<sup>39</sup> These individuals come from all walks of life and lack any formal training, yet are entrusted to assess intricate damage done to properties.<sup>40</sup> Furthermore, these adjusters' salaries are commensurate with the number of properties examined and not the quality of work, which makes a methodical investigation all the less likely.<sup>41</sup>

It is in this context that "adjusters" visit properties in the aftermath of a hurricane, conduct a quick and dirty investigation, and give a token check to the insured on the spot. To quicken these investigations, adjusters will use general facts of hurricane damage instead of evaluating an insured's unique loss.<sup>42</sup> Keeping in line with these generalized investigations, adjusters will refuse to consider hidden damage.<sup>43</sup> Although recoverable under the policy, hidden damage is viewed as a hindrance to settling a claim in a time effective matter, and considering hidden damage would result in more money being spent by the insurer to investigate.<sup>44</sup> Video of an insured receiving a \$5,000 check five days after a hurricane surely creates great publicity for the insurer, but the cameramen eventually leave and fail to record the adjuster never returning to the property. Instead, the insurer's claims department simply pays—or refuses to pay—the insured based on photos taken by

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<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

<sup>40</sup> *Id.*

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the unqualified adjuster. The hidden damage never gets investigated unless the insured investigates.

Such practices seem to fly in the face of various state unfair claims practices acts, which prohibit an insurance company from failing to adopt reasonable standards for the prompt investigation of claims and from refusing to pay a claim without first conducting a reasonable investigation.<sup>45</sup> These acts have regrettably produced little effect on running and gunning, which continues unabated after every natural disaster.<sup>46</sup>

## 2. Reinterpreting the terms after the fact

Most individuals purchasing property insurance are not experts and acquire insurance under the assumption that they will be covered if a flood or hurricane damages their property. Insurers add to this belief by erecting barriers to the insured's ability to examine the policy prior to issuance<sup>47</sup> and by including policy language subject to incredible interpretation. As such, although an insured does not expect its insurer to contest a claim arising from water damage, the insurer can point to a provision distinguishing among various types of water damage, reinterpret the provision any way it so chooses, and deny the claim.

## 3. Limiting risk through underpayment and releases

One of the most effective tactics employed by insurers is also among the simplest: underpay the insured. Following a natural disaster, the insured's property is often severely damaged or destroyed. As a result, the insured is vulnerable and desperate to receive some payment in order to afford temporary housing or prevent its business from going under. The insurer, acutely

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<sup>45</sup> See generally CAL. INS. CODE § 790.03(h) (Deering 2013); FLA. STAT. § 626.9541(i) (2013); MASS. ANN. LAWS ch. 176D, § 3(9) (2013); MINN. STAT. § 72A.20 (2013); MONT. CODE ANN. § 33-18-201 (2011).

<sup>46</sup> This conclusion is based on my thirty-two years of experience as a property insurance litigator.

<sup>47</sup> Daniel Schwarcz, *Reevaluating Standardized Insurance Policies*, 78 U. CHI. L. REV. 1263, 1321 (2011).

aware of the insured's precarious situation, quickly offers a meager payment that will only cover a fraction of the cost to repair or replace the property. The insured, already exposed and facing a lengthy court battle, reluctantly accepts this lowball offer.

Many insurers are not content to stop after receiving such a bargain. Instead, the insurer will often make this payment contingent on the insured signing a document that categorizes the payment as the full and final settlement and releases all future claims the insured might have under the policy.<sup>48</sup> The insurer accomplishes this feat despite the fact that the policy does not require a release in exchange for a claim payment and without providing separate consideration for this gratuitous release.<sup>49</sup> In essence, then, the insured releases its rights without receiving consideration in order to obtain performance to which it is already entitled.<sup>50</sup> The insured's need for immediate funds to house his family or keep her business afloat thus results in the insured receiving pennies on the dollar and being unable to properly repair his or her property.<sup>51</sup>

Underpayment occurs with alarming frequency. In 2006, the ten largest insurers in the United States paid out in benefits only about half of the money they received in premiums.<sup>52</sup> Underpayments are also becoming more prevalent, as payouts from property and casualty insurers decreased from sixty-seven cents for every premium dollar in 1987 to fifty-three cents per dollar in 2006.<sup>53</sup>

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<sup>48</sup> See Jay M. Feinman, *The Enforceability of Releases in Property Insurance Claims*, 19 Conn. Ins. L.J. 251 (2013).

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> See J. ROBERT HUNTER, PROPERTY/CASUALTY INSURANCE IN 2007: OVERPRICED INSURANCE, UNDERPAID CLAIMS, DECLINING LOSSES AND UNJUSTIFIED PROFITS, 19-20 (2007), available at [www.consumerfed.org/elements/www.consumerfed.org/file/finance/2007Insurance\\_White\\_Paper.pdf](http://www.consumerfed.org/elements/www.consumerfed.org/file/finance/2007Insurance_White_Paper.pdf); Valerie Jablow, *Insurers Continue to Overcharge, Underpay Policyholders, Study Finds*, TRIAL 71 (2008).

<sup>53</sup> Jablow, *supra* note 52.

#### 4. Third Party Intermediaries

Following a loss, an insurance company owes an insured two duties: to provide services to conduct a full and thorough investigation of loss and damages, and to pay for damages resulting from covered causes of loss.<sup>54</sup> Rather than fulfilling these contractual obligations themselves, as an insured would expect, insurance companies will hire third-party intermediaries to carry out these duties on behalf of the insurer. Third-party intermediaries often delay, complicate, and frustrate the insured's need for performance while insulating the insurer from any accountability. Independent adjusters, experts, and attorneys are the most common examples of third-party intermediaries involved in a claims process. Third-party intermediaries often lack any formal training in claims handling and have no duty to—or relationship with—insureds; their focus is entirely on the bottom line and maximizing profits for both themselves and their respective employers, and they ignore the needs of the insured whenever they conflict with this profit-oriented mindset.<sup>55</sup> As a result, third-party intermediaries have no qualms with breaking an insurer's promises, which ultimately creates costly litigation and further headaches for insureds.<sup>56</sup> Each third-party intermediary brings a different hidden conflict to their relevant step in the claims process, and they cannot be avoided if an insured has any hopes of having the insurer settle their claim.

##### a. Independent Adjusters

Following a loss, insureds expect a helpful hand from the insurance representative with whom they have spent years building a relationship. Instead, insurers will send out an unfamiliar independent adjuster who lacks any training in how to care for an understandably distraught insured. This juxtaposition creates the independent adjuster's hidden conflict:

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<sup>54</sup> This conclusion is based on my thirty-two years of experience as a property insurance litigator.

<sup>55</sup> JAY M. FEINMAN, DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON'T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT 56 (2010).

<sup>56</sup> *Id.* at 57–58.

when insureds need their insurer the most is when the insurer is the most unreachable. All communication between an insured and their respective insurer must go through the assigned independent adjuster, who is likely unfamiliar with the insured and their insurance history. Independent adjusters are purely bottom line oriented and possess none of the humanity elements portrayed by actors during an insurance company's commercial.<sup>57</sup> In most claims, an independent adjuster will use computerized adjusting to quickly evaluate damage.<sup>58</sup> During computerized adjusting, the adjuster uses a program called "Sketch" to draw a floor plan of the damaged areas and then adds in damaged items with their corresponding cost to reach a damage total.<sup>59</sup> Adjusters are unable to estimate above the settlement limit allowed by these programs.<sup>60</sup> This process decreases capital cost for insurance companies often at the expense of policyholders. The majority of insurance companies use some form of computerized claim handling.<sup>61</sup> This process completely ignores the unique characteristics of a loss in favor of a quick evaluation that lacks detail.<sup>62</sup> Insureds that find this process disagreeable are unlikely to receive a response from their insurer outside of a court room.

Not only do independent adjusters act as a communication barrier between the insured and the insurer, but they also cause miscommunication. Resources spent on training independent adjusters are kept to a minimum to protect the bottom line, and insurance companies do not consider experience in insurance

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<sup>57</sup> This conclusion is based on my thirty-two years of experience as a property insurance litigator.

<sup>58</sup> See FEINMAN, *supra* note 55, at 132.

<sup>59</sup> *Claims Estimating Overview*, XACTWARE, <http://www.xactware.com/en-us/solutions/claims-estimating/> (last visited Nov. 19, 2013).

<sup>60</sup> FEINMAN, *supra* note 55, at 72.

<sup>61</sup> DAVID J. BERARDINELLI, FROM GOOD HANDS TO BOXING GLOVES: THE DARK SIDE OF INSURANCE 127 (2008).

<sup>62</sup> "Xactimate is 'generic software' that is better suited to address 'cookie-cutter' homes." *Id.* at 133.

adjusting to be a requirement to be hired.<sup>63</sup> This indifference to quality and knowledge creates independent adjusters that are wholly underprepared for the needs of insureds. Independent adjusters often work for many different insurance companies, and confusing one company's policy language with another is common.<sup>64</sup> This miscommunication is made even worse following the chaos of a major natural disaster. To meet demand, insurers send out independent adjusters en masse, regardless of their experience with the loss type or loss area. Independent adjusters often end up working in states in which they are not actually licensed to adjust. This inexperience and mass confusion leads to frequent, wrongful rejections of claims. When a claim is too complex for an independent adjuster's computerized adjusting to handle, or if an insured disputes an independent adjuster's findings, an independent adjuster may be forced to call in an expert to investigate the property. Experts who should be an impartial, third-party are steered in the right direction by independent adjusters early on during their hiring process. Independent adjusters will include subtle clues in their correspondence with experts as to what the insurer hopes the expert will find, such as indicating what causes of loss are excluded and directly quoting relevant policy language, prior to the expert's first visit to the loss site.

#### b. Experts

Experts have a hidden conflict of being perceived as a source of unbiased reports by insureds while secretly owing their survival, and in turn their alliance, to insurers. An expert that can be counted on to return an insurer-favorable report is an expert that can count on being steadily employed.<sup>65</sup> The same expert firm may be used by an insurer thousands of times, with

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<sup>63</sup> See *Insurance Adjuster FAQ*, ADJUSTERPRO, <http://www.adjusterpro.com/insurance-adjuster-career/insurance-adjuster-faq.html> (last visited Nov. 19, 2013) (FAQ for individuals seeking a career as an insurance adjuster, repeatedly emphasizes the importance of "computer skills" over previous experience in insurance or construction).

<sup>64</sup> This conclusion is based on my thirty-two years of experience as a property insurance litigator.

<sup>65</sup> FEINMAN, *supra* note 55, at 128.

upwards of 90% of an expert's work consisting of investigations for the same insurance company.<sup>66</sup> This is particularly egregious because, unlike an independent adjuster, an expert does not represent himself as an official insurance employee to the insured.<sup>67</sup> As a result, the insured is led to believe the expert's estimate is an unbiased, fair value of their loss by an independent third-party.<sup>68</sup> In reality, an expert's estimate may be far less than the loss's true value.<sup>69</sup>

In addition to being outright bias, an expert's report is rarely confirmed or critiqued. Protecting one's reputation for producing reports that will stand up in court is far more important than creating an accurate report. As a result, experts will avoid any opinions contradicting their own.<sup>70</sup> Experts will actively avoid or outright ignore the insured's opinion on the loss.<sup>71</sup> Without the insured's opinion, the expert fails to gain critical information about the loss, and the resulting hypothesis is incomplete in its evaluation. An expert will make as few visits to the loss site as possible to prevent uncovering additional facts, often contrary to the insurer's wishes.<sup>72</sup> Investigation into hidden damages is nearly nonexistent, even though these hidden damages may cause substantial damage later on.<sup>73</sup> Through an attitude known as "confirmation bias," experts will

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<sup>66</sup> *Id.*

<sup>67</sup> *Id.* at 128–29.

<sup>68</sup> *Id.* at 129.

<sup>69</sup> *Id.*

<sup>70</sup> FEINMAN, *supra* note 55, at 127–128 (example of insurance expert performing a deliberately inadequate investigation).

<sup>71</sup> This conclusion is based on my thirty-two years of experience as a property insurance litigator.

<sup>72</sup> This conclusion is based on my thirty-two years of experience as a property insurance litigator.

<sup>73</sup> Expert's investigation failed to examine how much water had leaked from a broken pipe under insured's living room. *Id.* at 129.



refuse to consider facts or hypothesizes that negate their predetermined conclusions.<sup>74</sup>

An insurance expert's report is not subject to the same falsification standards required of academic papers.<sup>75</sup> Demanded under the scientific method, falsification requires an expert to test their hypothesis by attempting to prove the negative of the hypothesis or attempting to prove its failure.<sup>76</sup> Failure to engage in falsification and refusal to subject their findings to peer review results in a report that contains the unchecked opinions of only one individual. In other words, the opinion is not reliable. Yet the opinion is often the primary basis for an insurer's coverage opinion.

An expert's findings are presented to an insured with a "take it or leave it" mentality. An insured has no hope of receiving a second opinion on their loss or even a reinvestigation by the original expert. Thus, if the insured feels the expert's estimate is unacceptable compared to the damage actually suffered, a crossroad is met; the insured may either accept the expert's low-ball estimate or hire professional counsel and brace for a costly and prolonged litigation battle.<sup>77</sup>

### c. Attorneys

Insurer attorneys are almost exclusively hired on an hourly basis,<sup>78</sup> creating the hidden conflict of being employed to settle claims but receiving a higher payment the longer they can drag out a case. With this payment structure in mind, an insurer's attorney will prolong every stage of the litigation process. This

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<sup>74</sup> Richard G. Waterman, *Insurance Arbitration: Debiasing the Biased*, INS. ADVOC. (Dec. 12, 2011), <http://www.insurance-advocate.com/Insurance-Arbitration-Debiasing-the-Biased-c1294.html>.

<sup>75</sup> This conclusion is based on my thirty-two years of experience as a property insurance litigator.

<sup>76</sup> *Falsifiability*, PRINCETON, <http://www.princeton.edu/~achaney/tmve/wiki100k/docs/Falsifiability.html> (last visited Nov. 19, 2013).

<sup>77</sup> See BERARDINELLI, *supra* note 61, at 99–100.

<sup>78</sup> This conclusion is based on my thirty-two years of experience as a property insurance litigator.

postponement is achieved by interposing defenses that the attorney knows do not apply, engaging in unnecessary investigations by serving repetitive interrogatories and requests for productions, and delaying all responses until the deadline is reached.<sup>79</sup> These attorneys are well aware that the longer litigation is prolonged, the more likely an insured will admit defeat and accept the insurer's settlement offer.<sup>80</sup>

While independent adjusters and experts may operate under the guise of being there to help the insured, an insurer's attorneys make it clear that the insurer now considers the insured its adversary. The friendly demeanor is dropped, and punishing the insured for obtaining legal counsel becomes the underlying motivation for every action by the insurer.<sup>81</sup> Aggressive litigation tactics are used to both intimidate the insured into withdrawing their claim and send a warning to other would be claimants: sue and you will suffer.<sup>82</sup>

Repeated demands for compliance with post-loss conditions are made onto insureds. Any minor mistakes made during the claims process are seized upon in order to void the entirety of a claim.<sup>83</sup> Hostile examinations are taken under oath in an attempt to trick insureds into admitting non-compliance.<sup>84</sup> Baseless accusations of fraud are made against the insured to invoke fear of criminal proceedings if the insured does not back down.<sup>85</sup> Insureds are subject to financial punishment and time drains in order for the insurer to send a message: settlement of a claim may come, but only at a substantial price.

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<sup>79</sup> All States' use of investigations as an excuse to delay payment. See BERARDINELLI, *supra* note 61, at 97.

<sup>80</sup> *Id.* at 96.

<sup>81</sup> *Id.* at 98.

<sup>82</sup> *Id.* at 103.

<sup>83</sup> This conclusion is based on my thirty-two years of experience as a property insurance litigator.

<sup>84</sup> This conclusion is based on my thirty-two years of experience as a property insurance litigator.

<sup>85</sup> See BERARDINELLI, *supra* note 61, at 103.

#### d. Managing General Agents

Managing general agents operate one step above and beyond other third-party intermediaries. Instead of taking over one service for the insurer during the claims process, managing general agents completely take on the role of the insurance company when interacting with insureds, which creates the hidden conflict of operating as an insurance company without actually being an insurance company. While operating as an underwriter, managing general agents are able to evaluate an insured's risks and determine appropriate policy coverage.<sup>86</sup>

After a loss, managing general agents will settle an insured's claim under the same policy they wrote previously. Under this structure, an insured's policy is written, the loss is then evaluated, and the claim is ultimately settled without any input from an insurance company. With all of their traditional services executed by managing general agents, insurance companies function as only a bank providing funding. For all intents and purposes, managing general agents might as well be the insurance company.

This system of insurance companies hiding behind managing general agents creates massive accountability problems for the insured when a claim is wrongfully rejected. Although they are performing all of the duties of an insurance company,<sup>87</sup> managing general agents are not subject to the same state regulations as insurance companies,<sup>88</sup> thus frustrating the purpose of a regulation scheme and allowing for operation outside of prying eyes.

When an insured attempts to settle a claims dispute in court, insurance companies are able to use managing general agents as a barrier to the suit, thus eroding consumer protection. As managing general agents obscure the true interested party in an insurance contract, an insured may suffer through years of litigation before uncovering whom the truly liable party is.

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<sup>86</sup> *Managing General Agent*, IRMI, <http://www.irmi.com/online/insurance-glossary/terms/m/managing-general-agent-mga.aspx> (last visited Nov. 19, 2013).

<sup>87</sup> *Id.*

<sup>88</sup> This conclusion is based on my thirty-two years of experience as a property insurance litigator.

Managing general agents create a barrier between the insured and the insurer much like all other third-party intermediaries, but they create a much more inclusive barrier.

#### D. USING THE LAW AND THE SYSTEM TO THE FULLEST EXTENT POSSIBLE: PUNISHING THE CLAIMHOLDER

Many insurance companies came to view claims procedures from the 1970s and 1980s as undisciplined and overly reliant on an individual adjuster's discretion.<sup>89</sup> Believing that these practices resulted in consistent overpayment of claims, insurers renewed their focus on the bottom line, standardized practices, and removed any semblance of discretion.<sup>90</sup> This had the immediate effect of creating a new breed of adjustors who deny claims as a matter of right and, despite lacking a law license, interpret policies to exclude coverage.

Adjusters were not the only professionals to experience the ramifications of this profit-driven strategy. Eventually, it affected the insurer's attorneys. Although insurers tend to express no reservations with litigating claims into oblivion, pursuant to this redeveloped strategy insurers now examine their attorneys' billable hours with increased scrutiny.<sup>91</sup> The attorneys in turn are forced to find new ways to create revenue, and they often end up taking unprincipled stands in court in order to prevent an early disposition of the case.<sup>92</sup> Every motion is contested; requests for production go unheeded; and interrogatories are met with objections or left unanswered.<sup>93</sup> As a result, settlements today are few and far between, and previously routine coverage disputes now wind up in protracted litigation.<sup>94</sup>

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<sup>89</sup> FEINMAN, *supra* note 55, at 57-58.

<sup>90</sup> *Id.*

<sup>91</sup> *Id.* at 81-82.

<sup>92</sup> *Id.* at 83.

<sup>93</sup> *Id.* at 85.

<sup>94</sup> *Id.* at 83.

This increasingly adversarial process is further aggravated by an unexpected culprit: tort reform. The 1980s reduction of available damages in tort caused an exodus of litigators from the tort world into to the contract world. Little cordiality ever existed in tort litigation, so when these attorneys began litigating contract claims what little congeniality was left disappeared.

As a result, what used to be a levelheaded process has deteriorated to the point where insurers view their insureds with the utmost contempt. Insureds can no longer expect a straightforward or fair claims adjusting process, and, instead, they must prepare to meet heavy resistance at every step.

Uniformly, adjusters and experts for insurance companies limit their investigations to visible damage. This leads the insured to believe that there is no further damage. The results of hidden damage often manifest long after the claim is closed, which leaves the policyholder with no further remedy. The fact is, most policyholders never know the true value of their losses or what they are really owed.

## E. SCHEMES OF ARRANGEMENT

Perhaps the most facially persuasive argument insurers make in the wake of a catastrophe is that they simply cannot afford to pay all claims. The insurers point to the swath of devastation incurred, shrug their shoulders, and claim that paying every claim would render them bankrupt, which would subsequently cause thousands of insureds to lose coverage.

Insurers made such claims after Hurricane Katrina and the New Zealand earthquakes,<sup>95</sup> and they will likely make these claims following Superstorm Sandy. Insurers have found general success in this regard, as governments effectively bail out insurers and reduce consumer protections<sup>96</sup> while insureds accept reduced payments. Similarly, insurers use these catastrophes as grounds for raising premiums, which increased

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<sup>95</sup> See Sandra Block, *5 Years after Katrina, Homeowners Insurance Costs More*, USA TODAY (Aug. 26, 2010), [http://usatoday30.usatoday.com/money/industries/insurance/2010-08-26-katrina26\\_CV\\_N.htm](http://usatoday30.usatoday.com/money/industries/insurance/2010-08-26-katrina26_CV_N.htm)

<sup>96</sup> HUNTER, *supra* note 52, at 2 (2007).

an average of 30% in New Zealand following the series of earthquakes.<sup>97</sup>

If these claims were accurate, they would indeed be compelling. However, in reality insurers are “paying out lower claims, charging consumers higher premiums, reaping greater profits, and are more financially solid than at any other time in history.”<sup>98</sup> The stability of property and casualty insurers following a catastrophe is perhaps best demonstrated by U.S. insurers’ financial conditions post-Hurricane Katrina.

A straightforward indicator of how much an insurer pays in claims is the pure loss ratio, which compares total losses incurred in claims plus adjustment expenses with total premiums earned.<sup>99</sup> If an insurance company pays \$75 in claims for every \$100 collected in premiums, for example, the loss ratio is 75%. Accordingly, lower loss ratios represent higher earnings for insurers. The following chart represents U.S. property and casualty insurers’ pure loss ratios from 2000 to 2006:

<b>Year</b>	<b>Pure Loss Ratio</b>
2000	68.4%
2001	75.3%
2002	68.8%
2003	62.2%
2004	60.3%
2005	61.5%
2006	53.3% <sup>100</sup>

The pre-Katrina ratio average is 67%, yet the years including and following Katrina see the ratio dwindle to 61.5% and 53.3%.

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<sup>97</sup> Michael Dickson, *Insurance Shocks Hit Homeowners*, N.Z. HERALD (Jan. 23, 2012, 5:30 A.M.), [http://www.nzherald.co.nz/earthquakes/news/article.cfm?c\\_id=184&objectid=10780518](http://www.nzherald.co.nz/earthquakes/news/article.cfm?c_id=184&objectid=10780518).

<sup>98</sup> J. ROBERT HUNTER, PROPERTY/CASUALTY INSURANCE IN 2008: OVERPRICED INSURANCE AND UNDERPAID CLAIMS RESULT IN UNJUSTIFIED PROFITS, PADDED RESERVES, AND EXCESSIVE CAPITALIZATION 3 (2008), available at [http://www.consumerfed.org/elements/www.consumerfed.org/file/finance/2008Insurance\\_White\\_Paper.pdf](http://www.consumerfed.org/elements/www.consumerfed.org/file/finance/2008Insurance_White_Paper.pdf).

<sup>99</sup> *Id.*

<sup>100</sup> *Id.* at 5–6.

Similarly, 2006 was the property and casualty insurance industry's best year since 1988.<sup>101</sup> Property and casualty insurers had a \$600 billion surplus in 2006–2007, while Hurricane Katrina resulted in \$28.6 billion in damages after taxes.<sup>102</sup> The ratio of net premiums written to surplus provides further insight. Over time, the insurance industry has varied in expressing what it considers a prudent ratio, with most experts comfortable with ratios under 1.5 to 1 (1.5) or 3 to 1 (3).<sup>103</sup> Property and casualty insurers' ratio was 0.8 in 2005 and 0.7 in 2006.<sup>104</sup> Simply stated, the insurance industry became more profitable following Katrina. Reports of financial calamity are grossly misleading.

A more contemporary example can be found in insurer Ansvar's conduct following the series of earthquakes that hit Christchurch, New Zealand, in 2010 and 2011. Ansvar, which subsequently changed its name to ACS (NZ) Ltd, insured churches and historic buildings throughout Christchurch.<sup>105</sup> Following the earthquakes, Ansvar pursued a unique strategy of officially claiming solvency.<sup>106</sup> Yet they planted seeds of doubt by withdrawing from New Zealand,<sup>107</sup> cancelling all insurance policies,<sup>108</sup> threatening higher premiums,<sup>109</sup> and asking insureds

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<sup>101</sup> *Id.* at 7.

<sup>102</sup> *Id.* at 12.

<sup>103</sup> *Id.*

<sup>104</sup> HUNTER, *supra* note 98, at 13–14.

<sup>105</sup> Tamlyn Stewart, *Ansvar Settles 19 Larger Claims*, THE PRESS (Dec. 20, 2012), <http://www.stuff.co.nz/the-press/business/8101999/Ansvar-settles-19-larger-claims>.

<sup>106</sup> *Id.*

<sup>107</sup> Tamlyn Stewart, *Ansvar Fallback Scheme Worries*, THE PRESS (June 23, 2012), <http://www.stuff.co.nz/business/money/7156939/Ansvar-fallback-scheme-worries>.

<sup>108</sup> Hamish Fletcher, *Court Accepts Insurer's Plan for Insolvency*, N.Z. HERALD (June 20, 2012), [http://www.nzherald.co.nz/business/news/article.cfm?c\\_id=3&objectid=10814138](http://www.nzherald.co.nz/business/news/article.cfm?c_id=3&objectid=10814138).

to agree to a contingency plan in the event of insolvency,<sup>110</sup> which in turn caused the New Zealand Reserve Bank to voice concerns over the fairness to insureds who take longer to settle claims.<sup>111</sup> Ansvar's CEO even went so far as to suggest that those who settle their claims early—before Ansvar becomes insolvent—would receive a larger settlement.<sup>112</sup> Feeling this pressure, many insureds scrambled to settle and opted to receive a discounted claim rather than “risk” getting nothing at all.<sup>113</sup> Ansvar, perhaps unsurprisingly, remains solvent to this day.<sup>114</sup>

## V. SOLUTIONS

### A. GOVERNMENT ANSWERS

#### 1. New Zealand: Earthquake Commission

Well before the Canterbury earthquakes of 2010 and 2011, New Zealand enacted the Earthquake Commission Act of 1993.<sup>115</sup> Following a natural disaster, the Earthquake Commission Act provides monetary relief for damage to residential buildings and personal property for individuals who

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<sup>109</sup> Andrea Fox, *Huge Cost to Repair Shattered Churches*, THE PRESS (Mar. 4, 2011), <http://www.stuff.co.nz/national/christchurch-earthquake/4729854/Huge-cost-to-repair-shattered-churches>.

<sup>110</sup> Michael Wright, *Backup Insurance Scheme on Way*, THE PRESS, (Apr. 18, 2012), <http://www.stuff.co.nz/the-press/news/christchurch-earthquake-2011/6766841/Backup-insurance-scheme-on-way>.

<sup>111</sup> Stewart, *supra* note 107.

<sup>112</sup> Tamlyn Stewart, *Questions Remain Over Scheme*, THE PRESS (June 13, 2012), <http://www.stuff.co.nz/the-press/business/7092739/Questions-remain-over-scheme>.

<sup>113</sup> Stewart, *supra* note 105.

<sup>114</sup> See *ACS (NZ) Limited: Scheme of Arrangement*, ACS CLAIMS SERVICES, <http://www.acsclaimsservices.co.nz/ACS-scheme-of-arrangement/> (last visited Nov. 6, 2013) (explaining that the company continues “normal day to day operations. It is business as usual.”).

<sup>115</sup> Earthquake Commission Act 1993 (N.Z.).



already have insurance.<sup>116</sup> Although the Earthquake Commission Act has eased tension on some New Zealand insureds, others are left exasperated with the process,<sup>117</sup> and the cost weighs heavily on the state.

The Earthquake Commission (“EQC”) paid over \$4.1 billion as of January 2013;<sup>118</sup> the state’s reinsurance premiums more than tripled in the earthquake’s aftermath<sup>119</sup>; and the EQC has suggested that private insurers have attempted to shift costs onto the state.<sup>120</sup> Furthermore, the EQC’s efforts have not

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<sup>116</sup> Concerning residential property, the Act provides coverage equivalent to the lesser of

(a) if the contract of fire insurance specifies a replacement sum insured for which the building is insured against fire under that contract, the amount of that sum insured:

(b) if the contract of fire insurance does not specify such a replacement sum insured but does specify an amount to which the building is to be insured under this Act, that amount:

(c) the amount arrived at by multiplying the number of dwellings in the building (being the number determined in accordance with subsection (3)) by \$100,000 or such higher amount as may be fixed from time to time for the purposes of this paragraph by regulations made under this Act.

Earthquake Commission Act 1993 at § 8.

<sup>117</sup> “A Christchurch man threatened to douse himself in petrol and set himself on fire in Hagley Park in a last-ditch effort to resolve an insurance dispute over his quake-damaged house.” Matthew Backhouse, *Man Threatened to Burn Himself Alive Over Quake Insurance*, N.Z. HERALD (Nov. 15, 2012), [http://www.nzherald.co.nz/nz/news/article.cfm?c\\_id=1&objectid=10847689](http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10847689).

<sup>118</sup> Cullen Smith, *\$2b in Payouts to be Shared for Land Claims*, N.Z. HERALD (Jan. 16, 2013), [http://www.nzherald.co.nz/nz/news/article.cfm?c\\_id=1&objectid=10859446](http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10859446).

<sup>119</sup> Alan Wood, *CEO Hopes Premium Costs Will Settle*, THE PRESS (July 18, 2012), <http://www.stuff.co.nz/the-press/business/7120173/CEO-hopes-premium-costs-will-settle>.

<sup>120</sup> *EQC Reinsurance Costs Treble, Leaving Crown Vulnerable*, N.Z. HERALD (Dec. 5, 2012), [http://www.nzherald.co.nz/business/news/article.cfm?c\\_id=3&objectid=10852130](http://www.nzherald.co.nz/business/news/article.cfm?c_id=3&objectid=10852130); see also *Insurers Hit Back at Earthquake Commission*,

ameliorated the ills inherent in the property insurance industry; fewer than 300 houses were estimated to have been replaced in 2012, and insurance payouts moved at a “sluggish” pace.<sup>121</sup> In addition, a 2012 survey reported that 80% of respondents experienced delay in rebuilding, and many worried about “the death of elderly property owners exhausted by perceived dishonesty, dubious tactics, and double-dealing on the part of both EQC and insurers.”<sup>122</sup>

## 2. Australia: Financial Ombudsman Service

The Australian Financial Ombudsman Service (“FOS”) was established in 2008 to resolve disputes between consumers and financial service providers, such as insurers.<sup>123</sup> If an insured believes its insurer underpaid or wrongfully denied its claim, the insured can lodge a dispute with the FOS.<sup>124</sup> If the insurer and insured are unable to resolve the dispute directly, the FOS resolves the dispute through negotiation and conciliation.<sup>125</sup> If the parties still have not reached an agreement, the FOS will issue a determination that reads like an informal court opinion.<sup>126</sup>

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INSURANCENEWS.COM.AU (Nov. 19, 2012),  
<http://www.insurancenews.com.au/local/insurers-hit-back-at-earthquake-commission>.

<sup>121</sup> Susan Edmunds, *Quake Rebuilds Lag a Long Way Behind Claims*, N.Z. HERALD, (Sep. 30, 2012),  
[http://www.nzherald.co.nz/business/news/article.cfm?c\\_id=3&objectid=10837381](http://www.nzherald.co.nz/business/news/article.cfm?c_id=3&objectid=10837381).

<sup>122</sup> *Rebuild? Yeah Right. . .*, INS. WATCH (Dec. 13, 2012),  
<http://insurancewatch.org.nz/docs/Press%2orelease%20-%20December%2013%20-%20Rebuild%20Yeah%20Right.pdf>.

<sup>123</sup> *What We Do*, FIN. OMBUDSMAN SERV.,  
[http://www.fos.org.au/centric/home\\_page/about\\_us/what\\_we\\_do.jsp](http://www.fos.org.au/centric/home_page/about_us/what_we_do.jsp) (last visited Nov. 19, 2013).

<sup>124</sup> *See generally Our Dispute Handling Process*, FIN. OMBUDSMAN SERV.,  
[http://www.fos.org.au/centric/home\\_page/resolving\\_disputes/our\\_dispute\\_handling\\_process.jsp](http://www.fos.org.au/centric/home_page/resolving_disputes/our_dispute_handling_process.jsp) (last visited Nov. 6, 2013).

<sup>125</sup> *Id.*

<sup>126</sup> *See generally Determination: Case Number 244629*, FIN. OMBUDSMAN SERV. 5 (Sept. 26, 2011), available at

Home building and contents insurance disputes constituted slightly over 10% of all disputes in 2011 to 2012.<sup>127</sup> A majority of the disputes in this arena arose from insurers denying claims, making lowball offers, or delaying the handling of claims.<sup>128</sup> However, the FOS has received an influx of natural disaster related claims since 2010, which has delayed the processing of non-disaster related claims.<sup>129</sup> The FOS resolved approximately 70% of the 1,772 accepted natural disaster disputes over an eighteen-month period from 2011 to 2012.<sup>130</sup>

## B. WASHINGTON INSURANCE FAIR CONDUCT ACT: FIVE YEARS LATER

Perhaps recognizing the difficulties insureds face in dealing with property insurers, state legislatures have promulgated statutes aimed at punishing and preventing improper insurer conduct. In 2007, the state of Washington passed perhaps the most comprehensive of these statutes,<sup>131</sup> despite the insurance industry spending millions of dollars to force a referendum.<sup>132</sup> The statute forbids insurers from engaging in “unfair methods of competition” or “unfair or deceptive acts” and prohibits an

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<https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/244629.pdf> (finding that insurer should have indemnified insured for damage caused by Cyclone Yasi).

<sup>127</sup>Approximately 25% of all disputes accepted were general insurance disputes, 45% of which were home building and contents insurance disputes. FIN. OMBUDSMAN SERV., 2011–12 ANNUAL REVIEW 27, 36 (2012), available at <http://www.fos.org.au/custom/files/docs/2011-2012%20Annual%20Review.pdf>.

<sup>128</sup> *Id.* at 36.

<sup>129</sup> *Id.* at 38.

<sup>130</sup> *Id.* at 55.

<sup>131</sup> WASH. REV. CODE §§ 48.30.010–48.30.015.

<sup>132</sup> See David Postman, *Trial Lawyers Complain Insurance Industry's Ads are "Slanderous,"* SEATTLE TIMES (Sept. 14, 2007, 12:00 AM), [http://seattletimes.com/html/localnews/2003884052\\_postmanblog14m.html](http://seattletimes.com/html/localnews/2003884052_postmanblog14m.html). 56.7% of Washington residents voted to approve the statute. *November 06, 2007 General Election Results* (last updated Nov. 29, 2007), <http://vote.wa.gov/results/20071106/Referendum-Measure-67-concerns-insurance-fair-conduct-related-to-claims-for-coverage-or-benefits.html>.

insurer from “unreasonably deny[ing] a claim for coverage or payment of benefits to any first party claimant.”<sup>133</sup> An insurer that unreasonably denies a claim is liable for actual damages, attorneys’ fees, and litigation costs, and may be further liable for treble damages.<sup>134</sup> This approach has been generally received as a more effective method to deter insurer misconduct.<sup>135</sup>

Has this been effective to balance the playing field? Time will tell.

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<sup>133</sup> WASH. REV. CODE § 48.30.010(1), (7) (2013). Unfair acts include, *inter alia*, “[m]isrepresenting pertinent facts or insurance policy provisions,” “[f]ailing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies,” “[r]efusing to pay claims without conducting a reasonable investigation,” and “[a]ttempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.” WASH. ADMIN. CODE § 284-30-330(1)–(2),(4),(8) (2013).

<sup>134</sup> WASH. REV. CODE § 48.30.015(2) (2013). Criteria giving rise to triple damages include unfair or deceptive acts, misrepresenting policy provisions, failing to acknowledge pertinent communications, failing to promptly investigate a claim, and violating settlement standards. *Id.* § 48.30.015(a)–(e).

<sup>135</sup> For example, a recent article stated:

Legislation adopted in Washington expands the definition of first-party insurance bad faith and increases the damages awards available to policyholders in cases alleging insurer bad faith. The remedies specified in the act are separate and distinct from the remedies provided under common law as well as those prescribed in the state’s Consumer Protection Act. . . . This legislation represents a significant departure from most other states’ statutory approaches to first-party insurance bad faith, because it permits both unlimited punitive damages and does not contain a stringent standard of conduct for the awarding of such damages.

Sharon Tennyson & William J. Warfel, *The Law and Economics of First-Party Insurance Bad Faith Liability*, 16 CONN. INS. L.J. 203, 217 (2009) (internal citations omitted).

## VI. CONCLUSION

Until the hidden conflicts above are disclosed and accounted for, the use of third-party intermediaries will continue. Everyone involved is financially motivated, often at the expense of policy holders. Under this system, claims will be underpaid 100% of the time.

Property insurers continue to exceed profit expectations, despite natural disasters increasing in both number and destruction. Although common sense dictates that property insurers should struggle in a disaster's wake, insurers have avoided paying claims through developing techniques that are sometimes subtle, sometimes obvious, and always novel. Having lived through a hurricane or earthquake, insureds are often ill-equipped to properly handle these tactics, and insurers—despite state efforts at curbing such behavior—walk away unscathed.