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Whistleblower Sounds Alarm On Unfair Insurance Practices: Oregon Consumers Need Stronger Legal Protections

United Policyholders ("UP") is a national 501(c)(3) non-profit organization. United Policyholders has been assisting consumers, improving disaster resilience and recovery, and advocating for fair insurance practices, laws and regulations since 1991. Since 2020 and in partnership with public officials, agencies and non-profits in the State of Oregon, United Policyholders has helped wildfire-impacted Oregon residents through a Roadmap to Recovery program that includes educational webinars and *pro-bono* insurance legal assistance clinics.

United Policyholder's programming focuses on helping loss victims: understand their insurance policies and rights; accurately value losses; and be their own best advocates to collect what they are owed – *in full* – from their insurers.

Insurance funds are critical for people and communities to repair, rebuild and regain financial health after a catastrophic event. Based on the insurance claim experiences that Oregon residents are reporting to United Policyholders, it is clear that more needs to be done in the state to deter and prevent unfair practices.

In early September, 2022 a wildfire survivor contacted United Policyholders to alert our organization that the adjuster who'd been very competently handling her 2021 claim had contacted her in tears to notify her that she'd just been terminated. The survivor connected United Policyholders with the terminated adjuster, an experienced claim professional who had been adjusting losses in Oregon and California for a major insurer, (including the wildfire survivor's claim).

For purposes of this special report, we will reference the terminated adjuster as a whistleblower. From the facts reported to United Policyholders, it appears that the whistleblower had been recently terminated by an insurer for correcting mistakes made by other adjusters who had failed to pay the full amounts owed to Oregon wildfire victims. The wildfire survivor who'd connected the whistleblower to United Policyholders confirmed that the whistleblower had handled her total wildfire loss claim fairly and corrected errors that another adjuster had made. After the errors were corrected, the wildfire survivor had recovered additional funds from the insurer thanks to the whistleblower's diligence. The whistleblower appears to have been terminated as a result of her diligence on that and Oregon claims, some of which are described below.

Along with this whistleblower's allegations, United Policyholders has received numerous reports from Oregon consumers who were forced to undergo an egregiously difficult and unfair claims handling process after losing their homes in a wildfire.

The whistleblower's alarm and these consumer reports make it abundantly clear that existing Oregon law needs to be strengthened in order to provide more deterrence and stronger protections against unreasonable delays, lowballing, and unfair insurance practices.

As Oregon law stands today, it is not financially feasible for an average citizen or small business to retain a lawyer and undertake a lawsuit to challenge unfair treatment by an insurance company.

An Adversarial and Unfair Insurance Claim Process Wastes Time and Money

When an event occurs that damages or destroys a person's home or business, insurance funds make the difference between recovery and ruin. Yet insurance funds often do not flow as quickly or fully as they should. Insurance companies have designed complicated processes – including recoverable and non-recoverable depreciation as well as proof requirements – that confuse even the most educated consumer.

United Policyholders teaches free classes that cover the nuts and bolts of estimating and valuing losses and help people navigate the complicated system insurers have created. *See* https://uphelp.org/recovery/. United Policyholders also advocates for strong laws and regulations to prevent insurers from paying less than what they owe on a claim by exploiting consumers' lack of experience with the overly complicated systems designed by the insurance companies themselves.

Logic and fairness dictate that on total wildfire loss claims where there is no question of arson (the claimant did nothing to cause the event that destroyed their home), there should be fewer claim hoops to jump through. After a wildfire, one would

expect an insurance company to quickly and efficiently disburse funds to impacted insureds so they can commence the painful and arduous process of replacing possessions and rebuilding lives and homes. But the sad reality is that after a natural disaster, insurance companies facing hundreds of large losses at one time have a heightened financial incentive to slow and limit payouts to protect their bottom-lines. Part of the way insurers unfairly protect themselves to the detriment of consumers is by stalling payouts, confusing claimants with depreciation math, and failing to respond in a timely manner to loss estimates, reports and communications.

While the Oregon Legislature and Department of Insurance have both recognized and responded to these concerns with rules intended to help consumers, the reports United Policyholders has received confirm that stronger protections are needed. Under current Oregon law, the most an insurance company can lose from a lawsuit for improper denial of a claim and unfair claim practices is the cost of fairly paying the claim in the first place (the amount due under the insurance policy). As a result, insurance companies know that the cost to most insureds to retain counsel to fight to collect what they are rightly owed will significantly erode, and in many instances exceed, the amount of unpaid insurance benefits. As a result, legal recourse is not a feasible or affordable undertaking. That is not a healthy system for Oregon property owners, and it needs to be fixed.

An Insurer's Duty of Cooperation Includes Extending Deadlines Where Appropriate

The Oregon Department of Consumer and Business Services Division of Financial Regulation (ODCBS) recently issued Bulletin No. DFR 2022-3. In the Bulletin the ODCBS noted that insurers were not investigating or acknowledging widespread rebuilding delays associated with Labor Day 2020 wildfire losses, compounded by material and labor shortages, inflation and COVID-19 related supply chain disruption. The OCBS also found evidence that insurers were ignoring communications from consumers about rebuild issues and delays outside of the insureds' control. It found that failures to communicate, investigate, or consider relevant information might be inconsistent with insurers' obligations under the Insurance Code and constitute violations of ORS 746.230 and ORS 746.240. Because of these failures, the ODCBS directed insurers to provide an extension of time for homeowners to rebuild their home and replace their personal property.

The ODCBS noted that under Oregon law, the Insurance Code requires that all insurers:

- Promptly and truthfully reply to division inquiries regarding any matter connected with its insurance business;
- Conduct a reasonable investigation based on all available information;
- Acknowledge and act promptly upon communications relating to claims;
- Promptly and equitably settle claims in good faith;

- Adopt and implement reasonable standards for the prompt investigation of Claims.

The Insurance Code also prohibits insurers from:

- Requiring a claimant to litigate by offering substantially less than the amount ultimately recovered by the claimant;
- Engaging in a general business practice of refusing to pay or settle claims without just cause.

As demonstrated by the whistleblower's allegations and other reports provided to United Policyholders, it appears that insurers, and their overworked and poorly trained claims adjusters, are routinely violating many of the requirements of the Oregon Insurance Code.

Allegations According to the Whistleblower

1. Single Mother Unfairly Denied Extension of Temporary Rent Benefits

The whistleblower worked with a single mother who held two jobs and had three children in the home. Like many of those whose homes were destroyed in the 2020 Labor Day Fires, the single mother was working on, but had not yet been able to complete, her rebuild project. The single mother therefore needed her insurer to extend her temporary housing benefits until the rebuild was complete.

There was no dollar amount in the insurance policy for temporary housing money, so it was entirely appropriate and consistent with Oregon law that the insurer grant the request for an extension. There was ample evidence that the policyholder had been working diligently to rebuild her home: the policyholder had hired a contractor in April 2021; had received a permit in April 2022; foundation work had been completed in August 2022; and the policyholder was pursuing a construction loan. Despite all the progress, the insurance company refused to extend time stating it took the policyholder eight months to obtain a construction loan. The insurance company also failed to assess or cover the full amount of driveway replacement costs or reimburse the policyholder for receipts submitted in an attempt to receive benefits for replacement cost of personal property.

The policyholder submitted the OR Bulletin DFR 2022-3 to the insurance company asking again for an extension which reopened the claim. The original adjuster and team manager refused to revisit the claim. An adjuster colleague agreed there was a justification for an extension. Ultimately, the whistleblower and homeowner had to repeatedly request reassignment and resubmit information. After serious delays and loss of time to complete reconstruction, the claim was reassigned and the insurer extended benefits including over $14,000 in owed in benefits for fencing, driveway, and replacement costs.

2. **Elderly Policyholder Denied Necessary Housing Benefits After Two Strokes**

The whistleblower also worked with an elderly woman whose claim was being handled by an adjuster who ignored phone calls and denied requests for an extension of time to submit paperwork. The policyholder's insurance agent endeavored to help the policyholder by contacting the whistleblower, whom the agent knew to be a competent and expert claims adjuster. Together, the policyholder, agent, and the whistleblower sought an explanation as to why the elderly woman's extension request had been denied.

The agent's office, along with the policyholder explained the policyholder had suffered two strokes after the fire which had delayed the rebuild even though the policyholder was working diligently within her means to secure a contract and complete the rebuild. The elderly insured had a homeowner's policy and a rental dwelling policy. The policyholder explained that she had been able to replace her home with a modular home, but was struggling with the time frame to get a contract signed and submitted so she could receive approximately $50,000 in replacement cost coverage by September 6, 2022.

The policyholder also questioned why the septic, well, and some electrical were not included in the insurance company's estimate. The whistleblower reviewed the estimate and determined that none of those items were in the woman's claim file though they should have been. Nevertheless, the insurer's senior representative only noted "The delay appears to be due to PH's indecision as to how to proceed with rebuild and who to hire, despite our efforts to assist her. I do not see any delays by [insurer]."

3. **Termination for Doing One's Job**

Ultimately, the whistleblower appears to have been terminated for suggesting the denied extensions required additional review and paying what was owed to policyholders under the terms of their insurance policies and applicable law and regulations.

Consumer Testimonials Submitted to United Policyholders

In addition to the whistleblower's report, United Policyholder has received numerous testimonials from policyholders who faced similar unfair investigation and settlement practices.

Traditionally, insurance companies require policyholders to submit a detailed inventory (with line-items as specific as the number and brand of toothbrushes in a bathroom) of all destroyed personal property to receive the depreciated value of that property. The depreciated value is some fraction, often ranging from 20-60%, of the price to replace the object. To receive the full replacement price, the insured must submit another receipt for each item actually repurchased as the insured goes about

the process of rebuilding and replacing their property. Many insureds forego the additional hurdle of keeping a detailed set of receipts and therefore fail to recover the full value of their insurance. While this process may make sense for an insured seeking coverage for a single large household item, it is an extremely burdensome process for those who have suffered total losses. But by inflexibly applying the same rules, insurance companies are able to hide behind roadblocks of their own creation and effectively decrease the amount they owe to their insureds.

While each policyholder faces their own specific issues based on the facts of their claim, the overall themes are the same: homeowners often feel overwhelmed, confused, and taken advantage of by the claims adjusting process after a total loss.

A selection of Oregon residents gave United Policyholders permission to publish their stories. A few representative examples are included here. While United Policyholders is aware that many homeowners are treated well by their insurance companies and promptly receive the benefits they are owed, the following examples are unfortunately common and typical of experiences that individuals go through following a disaster-related total loss.

1. **Policyholder Testimonial by "M.A.T."**

> My wife and I suffered catastrophic fire losses on September 8, 2020. Our insurer's handling of our claim added insult to injury. We were assigned an adjuster the week after the fire. She was the best of the four adjusters we had, but she was removed after four months and sent to Texas for the Big Freeze. The next person assigned to us didn't know our case and kept having to refer back to old information over our two to three months with him – even though it had already been sorted out. The third adjuster assigned to us was a rookie, and ill-trained, who wanted to start from the beginning on our claim even though we were over half a year into process. Thankfully we only had him for about six weeks.
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> Then we were assigned a fourth adjuster, who was a robot and seemed to be reading from a script. She challenged a number of our losses on technicalities and seemed to fail to spend any energy on actually evaluating our claims. For example, any item over $500 was paid out at 20-40% while anything under $500 was paid out at 60-80% regardless of condition. The whole process seemed arbitrary and that the discounts were driven by a desire to limit our payout on more expensive items rather than actually evaluating our contents. Ultimately, we received on average 64% payout.
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> The most egregious mentally and emotionally distressing part was that from the beginning none of these adjusters could or would tell us the total amount we had coming under our coverage for the rebuild. We were given replacement value within four months, but the full amount we were owed to rebuild was delayed and delayed and all the while we had no idea what it would even end up being. To resolve the issue, I had to go to my agent of 35 years to have him help us find out the total amount, so we wouldn't have to take out a loan. Within days he had completed a spreadsheet, figured out we were still owed roughly $85,00 and then worked to go above our adjuster's head to help us get our payment. Why was I required to go to my agent to resolve a claims handling issue that should have been resolved months earlier? Without that personal relationship, we maybe would still be working to receive the amounts we were owed.

2. Policyholder Testimonial by "J. K."

Our experience is framed by the fact that we had a total, 100% fire loss. Nothing was salvageable. Because we lost everything, it should have been relatively straightforward to pay out our claim.

To be fair, our process began smoothly with a kind and helpful adjuster who made sure (in what I assume is standard practice) to get us some money quickly. But the amount of that money was severely limited pending completion of a detailed inventory of our personal property and review by the insurance company.

At that point, the real struggles began. We were pointed to certain proprietary software (called Contents Collaboration) into which we were supposed to digitally enter each and every item of personal property that we lost in the fire. Every item was to be categorized by room, identified by brand, model number or other identifying data, vendor from whom purchased, purchase date and original purchase price, and then with replacement cost paid, date replaced and from whom purchased.

This was literally, an impossible task for numerous reasons. To begin, the software did not even work properly – I could not scroll through items or click on an item without an involuntary scroll occurring. I am relatively computer savvy and well educated. I can't imagine anyone older than myself (age 72 at the time) or anyone without computer skills being able to understand, let alone use their software. Further, we lost everything, so identifying (through memory and photographs) what we lost was a task beyond capability. There was no way we would or ever could identify every single item lost. Yet, that was what we were asked to do. And, as we began to replace certain items, we then had to supply receipts for each and every item replaced.

Frustratingly, our adjuster had no authority and no logical or practical way to deal with us on a total loss situation. I tried in vain to suggest a simple settlement solution. For example, with $223,000 worth of replacement cost coverage for contents, we knew we would never exceed the limits, so we suggested settling the contents coverage (with a release of claims, I might add) for $100,000 This was less than 50% of our coverage limits, but it was completely rejected out-of-hand. The insurance company wouldn't even discuss the possibility of reasonable settlement to allow us to receive fair compensation in a prompt manner and avoid countless hours unnecessarily detailed and impossible work.

I finally brow beat one adjuster into asking for and getting permission to pay us about 30% of our coverage limits, which brings me to my last two points.

From start to finish, we went through eight separate individual adjusters. It seemed every time we began to make some progress with an adjuster, the company would assign a new one to us. It was so very frustrating and very confusing because we had to remake all our arguments for coverage over and over again.

For example, we had to repeatedly argue with the adjusters over the size of our rebuilt home (which actually ended up 110 sq. ft. less living space than the home we lost). In another case, I was asked to prove that we had lost a colored vinyl fence (which is apparently more costly than a white vinyl fence), when there were surface level photos of the lost home available on the internet. In addition, in trying to itemize our contents, the adjusters almost seemed to beg us to lie about what we had, proposing over and over again a long litany of suggested contents. We literally could have said, "Oh, yes, we had mink coats," for example. No one could have proven that we didn't have them. But we never

lied, and yet, when I said we had a colored vinyl fence, the adjuster insisted that I prove that it was colored and not just white.

The entire experience was demoralizing, excessively and unnecessarily complicated and time consuming. I personally spent a hundreds of hours of my time trying to identify and describe contents to eight different adjusters over about 18 months. The adjusters also spent hundreds of hours poring over what I sent and trying to justify what we asked for.

There just has to be a simpler way to avoid the human and financial costs of settling a total loss claim like ours. I used to bill my time at $250 per hour. I'm guessing an adjuster's time is worth at least $250 per hour in today's world. Our combined time, at those rates, was worth something in the range of $75,000 to $150,000. Yet, the company would not settle our contents claim for less than 50% of our coverage limits, and in the process, instead spent all of that and more in hired adjusters' time. Illogical. There has to be a better way.

3. Policyholder Testimonial by "T.B"

I had several adjusters. Temporary living payments were not explained adequately. The adjuster said they would pay me monthly rent and allowance if I got an RV and placed on the property. But then they denied that and only paid me for a used RV I bought. If I would of know that buying a more suitable RV later would result in a denial, I would have bought a better RV in the first place. It was very poor communication from the first adjuster that resulted in leaving significant money on the table for me.

Later, a new adjuster withheld for over a year the additional insured amount for re-construction, even when I submitted a builder estimate. She demanded that it be put in the insurance companies special format, but no one in the construction industry uses their estimating format. My builder called several times to discuss and never got anywhere with this adjuster. I was forced to go to the Oregon Insurance Commission. The insurance company finally paid the rebuild amount and some others that I did not know they were withholding. Ultimately, I don't know what I left on the table with the insurance company as I'm not sure what was not paid out.

I had several pieces of farm equipment insurance, but because of the age the insurance company depreciated it down drastically even though I could not replace it for like kind, i.e., the same year for the value I received. For example, I had 1985 D4D cat insured for $20,000, I received $8,000 for it, but it cost me $35,000 to replace it. I had some of equipment insured for $150,000, but I only received $90,000. However, I paid premiums for $150,000 coverage. How is this right? To replace everything that I lost on this policy would be well over $200,000.

In terms of my personal property, at first the adjuster wanted pictures of what I had even when I tried to explain it was a total loss and I did not have pictures. It took me 18 months to finally create a detailed list of the property I lost. I ended up far exceeding the limits of the policy. It seems to me in a total loss they should just pay your limits of the policy, particularly when it's obvious from the start that the limits will be reached. I know some other insurance companies just did that. A lot of emotional stress was added by doing the inventory and the amount I received was delayed by over a year.

The bottom-line is that there was a large gap between what I was insured for and what I received, and on top of that, there was the emotional stress you go through dealing with the insurance company.

Conclusion

An insured person or business that suffers a loss after having bought insurance to protect their assets is entitled to be fully indemnified as provided by the terms and conditions of their policy and applicable law. When one pays premiums for insurance, one pays for coverage *and fair and reasonable claims handling.* One should not have to file a lawsuit and pay a professional on top of that to collect what they're owed on a loss. That is commercial fairness, common sense, and the basis of a healthy loss indemnification system.

But given the ever-present temptation for insurers to slow pay, low pay and intimidate policyholders and avoid paying what they owe in full and on time, the law must provide adequate remedies, penalties and rewards.

For the benefit of Oregon's residents and communities, state law needs strengthening to make it financial unwise for insurers to unfairly underpay. As long as insurance companies face few to no negative consequences for delaying and improperly limiting payouts, it will remain in their financial interest to do so.