IN THE SUPREME COURT OF THE STATE OF OREGON

CHRISTINE MOODY, individually, and in her capacity as the Personal Representative of the Estate of Steven "Troy" Moody, Deceased,
Plaintiff-Appellant/Respondent on Review,

v.

OREGON COMMUNITY CREDIT UNION, aka OCCU, an Oregon entity, association, union, or corporation et al.,
Defendants,

and

FEDERAL INSURANCE COMPANY, an Indiana corporation,
Defendant-Respondent/Petitioner on Review.

Court of Appeals
A172844

S069409

BRIEF ON THE MERITS OF *AMICUS CURIAE* UNITED POLICYHOLDERS IN SUPPORT OF RESPONDENT ON REVIEW

On Review of the Decision of the Court of Appeals
on appeal from a Limited Judgment of Dismissal of
Lane County Circuit Court, Honorable Bradley A. Cascagnette

Opinion Filed: January 26, 2022
Author: Senior Judge Landau
Concurring: Presiding Judge Powers and Judge Egan

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September 2022

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I. INTEREST OF AMICUS CURIAE

United Policyholders ("UP") is a highly respected national non-profit section 501(c)(3) organization. Founded in 1991, UP has served as a voice for the interests of insurance consumers across the country for more than 30 years. Individual policyholders routinely call on UP for help in the wake of large-scale national disasters, such as hurricanes in the Gulf of Mexico and across the Eastern Seaboard; floods and windstorms in the Midwest; wildfires in the West; and, most recently, the novel coronavirus disease 2019 ("COVID-19") pandemic. UP has been assisting Southern Oregon residents impacted by 2020 wildfires in coordination with public officials in the region.[1]

UP routinely engages in nationwide efforts to educate the public, governmental agencies, legislators, and the courts on policyholders' insurance rights. Grants, donations, and volunteers support UP's work, which is divided into three program areas:
(1) Roadmap to Recovery (disaster recovery and claim help),
(2) Roadmap to Preparedness (insurance and financial literacy and

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[1] https://uphelp.org/disaster-recovery-help/oregon-wildfires-insurance-claim-and-recovery-help/.

disaster preparedness), and (3) Advocacy and Action (advancing pro-consumer laws and public policy). UP does not sell insurance or accept money from insurance companies.

Public officials, state insurance regulators, academics, and journalists throughout the United States routinely seek UP's input on insurance and legal matters. UP serves on the Federal Advisory Committee on Insurance, which briefs the Federal Insurance Office and, in turn, the U.S. Treasury Department. UP's Executive Director has been an official consumer representative to the National Association of Insurance Commissioners since 2009. In these roles, UP assists regulators in monitoring policy language and claim practices through presentations and collaboration and the development of model laws and regulations.

UP chooses cases cautiously before it appears as *amicus curiae* nationwide. UP's briefs provide a counterweight to the claims of the insurance industry and facilitate evenhanded development of the law. Since 1991, UP has filed numerous amicus briefs in federal and state appellate courts across the country that seek to uphold the indemnity function of insurance. The United States Supreme Court and state supreme courts have cited UP's amicus briefs and studies

in their opinions. *See, e.g.*, *Humana Inc. v. Forsyth*, 525 US 299, 314 (1999); *Preferred Contractors Ins. Co., Risk Retention Grp. v. Baker & Son Constr.*, No. 100466-4 at 8 (Wash. Aug. 11, 2022); *Sproull v. State Farm Fire & Cas. Co.*, No. 126446, 2021 WL 4314060 (Ill. Sep. 23, 2021); *Pitzer Coll. v. Indian Harbor Ins. Co.*, 8 Cal 5th 93, 104-105 (2019); *Cont'l Ins. Co. v. Honeywell Int'l, Inc.*, 188 A3d 297, 322 (N.J. 2018); *Ass'n of Cal. Ins. Cos. v. Jones*, 2 Cal 5th 376, 382-383 (2017).[2]

UP continues its mission of supporting policyholders through its amicus efforts here in support of Plaintiff-Appellant/Respondent on Review Christine Moody, individually and in her capacity as the personal representative of the estate of Steven "Troy" Moody, Deceased.

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[2] A list of *amicus curiae* briefs filed by UP can be found at https://www.uphelp.org/resources/amicus-briefs (last visited Sept. 7, 2022).

II. INTRODUCTION

This case presents issues of critical importance that will affect the rights of numerous Oregon insureds—consumers and businesses—who find themselves in a financial crisis and desperately need not just insurance benefits, but to be treated fairly by their insurers.

The main question on review is simple: when an insurance company denies insurance benefits to an insured in a manner that violates an Oregon statute that prohibits such denials, can the insured bring a negligence *per se* action against the insurance company?

The Unfair Claims Settlement Practices Act, ORS 746.230 ("UCSP Act"), provides that an insurer may not commit or perform fourteen "unfair claim settlement practices," including refusing to pay claims without conducting a reasonable investigation or failing to attempt in good faith to promptly and equitably settle claims when liability is reasonably clear. ORS 746.230(d), (f).

In this case, the insured—Ms. Moody—alleges that the insurance company violated ORS 746.230 and caused her to suffer severe emotional distress when it unreasonably denied her claim for

benefits under a life insurance policy after the accidental death of her husband. Because she has no other means for recovery, Ms. Moody seeks to recover her emotional distress damages against the insurer based on a negligence *per se* theory.

The insurance company moved to dismiss Ms. Moody's negligence *per se* claim and strike Ms. Moody's request for emotional distress damages, maintaining that a negligence *per se* claim may not be predicated on a breach of an insurance policy. The trial court agreed and granted the insurance company's motions.

The Oregon Court of Appeals reversed, concluding that the trial court erred and holding that the insured adequately pleaded facts which, if true, would allow liability for negligence *per se*. In a thorough and sound opinion, the court explained that ORS 746.230 creates a common law standard of care independent of the terms of an insurance contract, and that as a member of the insurance buying public, Ms. Moody is within the class of people protected by that statute. Specifically, the court explained:

> "especially given that the very nature of insurance is that it is purchased to ensure peace of mind, it is hard to imagine that the legislature did not intend the law, at least in part, to

> prevent policyholders from being forced to experience the stress of dealing with unfair insurance claim settlement practices."[3]

Thus, as the court agreed, in addition to providing compensation on a covered loss, a broadly recognized purpose of insurance is to provide economic and financial peace of mind to the insured. It follows that emotional distress is within the range of harms that ORS 746.230 was adopted to prevent.

III. ARGUMENT

A. Oregon Consumers Routinely Encounter Abusive Insurer Practices When They Most Need to be Treated Fairly, Despite Regulatory Oversight of the Industry

Under the UCSP Act, only the Oregon insurance commissioner, part of the Oregon Department of Consumer and Business Services ("DCBS"), has direct enforcement power to address unfair claims practices prohibited by the statute. But, as explained by the Oregon Court of Appeals, the lack of an explicit private right to action under the statute does not mean that a consumer is precluded from using the basic standards of care established by the statute for the purposes of a claim for negligence *per se*.[4]

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[3] ER 81.

[4] ER 77.

One common assertion from the insurance industry is that the current regulatory scheme in Oregon is sufficient to deter insurer misconduct. That is not accurate. Judging from the consumer communications that UP and its long-term recovery partners in Oregon have been receiving since the 2020 fires, Oregon residents are routinely subjected to unfair claim practices, and the Division of Financial Regulation ("DFR") cannot provide the level of individualized claim and legal assistance that people need to remedy these practices.[5]

The Legislature has recognized that the UCSP Act, which has been in place in one form or another since 1967, has not deterred insurer abuses. In the run-up to the 2013 Legislative Session, members of the Oregon Legislature believed that the Act was not sufficiently effective in deterring misconduct or achieving justice for Oregonians. Therefore, during that legislative session, the Oregon

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[5] *See Whistleblower Sounds Alarm on Unfair Insurance Practices: Oregon Consumers Need Stronger Legal Protections*, United Policyholders Special Report (Sept. 13, 2022) ("UP Special Report"). A printout of the UP Special Report is attached as Appendix A to this brief. The report is also available at https://uphelp.org/media/studies-reports-and-articles-on-insurance-issues-and-industry-practices/ (last visited Sept 14, 2022).

legislature heard testimony from Oregonians regarding the gaps left by the current regulatory regime for addressing claims for insurance benefits. In particular, volunteer advocates advised of numerous instances in which they were unable to reach agreements with insurers to assist consumers with claims for insurance benefits. This "left [advocates] with few options to protect [Oregon] consumer's rights, even with the support of the Oregon Insurance Division."[6]

Therefore, to help "strengthen the ability of our regulators to protect consumers,"[7] the Oregon legislature granted DFR the authority to institute an action or proceeding to "[s]eek restitution on a consumer's behalf for actual damages the consumer suffers as a result of the insurer's violation of a provision of the Insurance Code or applicable federal law or the insurer's breach of an insurance contract or policy the insurer has with the consumer." Or Laws 2013,

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[6] Testimony of Paul Terdal, NW Portland (HD36 / SD18) to Rep. Chris Garrett dated June 24, 2013. The DFR, which regulates insurance in Oregon, is part of the Department of Consumer and Business Services ("DCBS"); the Director of DCBS is also the state's insurance commissioner. *See* https://www.oregon.gov/dcbs/news-info/pages/about-us.aspx (last visited Sept 14, 2022). The DFR is sometimes referred to as the Oregon Insurance Division.

[7] *Id.*

ch 618, § 1, amending ORS 731.256(2)(a); OAR 836-007-0001(2) ("The Director of the Department of Consumer and Business Services: (a) May seek restitution of actual damages or other equitable relief on a consumer's behalf *only when* the director takes an action against an insurer under ORS 731.256(1).") (emphasis added).

But despite the good intentions behind this limited change in the regulator's authority, even this new authority has not succeeded in deterring unfair insurance claims practices. Insurance industry abuses that appear to be violations of the Act are commonly reported to lawyers, agents, and advocacy organizations like UP. UP has received many complaints from homeowners who lost their homes in the 2020 wildfires, stating that insurers have forced homeowners through onerous and complex procedures designed to delay and preclude coverage for claims, resulting in not only delayed payments but emotional stress arising from an experience described as "demoralizing, excessively and unnecessarily complicated and time consuming," "egregious," and "mentally and emotionally distressing."

For example, UP received reports that insurers failed to reasonably extend deadlines to rebuild, which is necessary for

homeowners to obtain full replacement cost recovery that they paid for.[8]

Insurers also commonly impose unreasonable hurdles to obtain personal property coverage, including forcing homeowners to complete a detailed inventory in a situation where there has been a total loss and it is clear that limits will be reached.[9] As one homeowner described the onerous process:

> "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 . . . . Further, we lost everything, so identifying (through memory and photographs) what we lost was a

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[8] This behavior has become such a distinct problem that in 2021 the Oregon legislature passed House Bill 3272, which prospectively requires insurers to give homeowners a reasonable amount of time to rebuild.
See https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB3272/Enrolled (last visited Sept 10 2022). Obviously, this legislation would not have been needed if the insurance industry were treating every homeowner with due consideration for the consumer's interests.

[9] *See* UP Special Report at 7.

> 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."[10]

As another homeowner reported, "a lot of emotional stress was added" by creating a contents inventory and that "[i]t took me 18 months to finally create a detailed list of the property I lost."[11]

Homeowners also report suffering frequent delays in the adjustment and payment of their claims because insurers often change adjusters many times.[12] In some instances reported to UP, insurers have changed assigned adjusters as many as eight times in the course of two years.[13] The complaints received by UP about this practice generally tell the same story: each change of adjusters creates delay because the new adjuster needs time to find and/or review the file.

These types of abusive behaviors are enormously frustrating to consumers (and businesses) even under the best of circumstances.

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[10] *Id.*

[11] *Id.* at 8.

[12] *Id.* at 6.

[13] *Id.* at 7.

But where the policyholder has lost *everything* in a wildfire, is suffering from medical conditions or emotional distress from the loss, is in default on a bank loan, cannot service its customers and may lose them, or is in some other way already at a disadvantage, what may seem like minor annoyances to the privileged become debilitating hurdles to getting the recovery that was promised by their premiums.

That is the kind of story presented by a whistleblower who recently contacted UP with an extraordinary story after being fired by her insurance company employer for attempting to secure contractually-owed policy benefits for wildfire victims.[14] The whistleblower reported two instances in which the insurance company refused to extend benefits, despite the policyholders' diligent efforts to replace their destroyed homes and possessions. Ultimately, the whistleblower appears to have been terminated for paying what was owed to policyholders under the terms of their insurance policies and applicable law and regulations.[15]

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[14] *Id.* at 5.

[15] *Id.*

In summary, Oregon consumers continue to struggle with insurers committing unfair claims settlement practices, causing significant extra-contractual damage, despite legislative interventions and regulatory oversight of the industry.

B. A Negligence *Per Se* Cause of Action Would Hold Insurers Minimally Accountable

Any argument that the court of appeals somehow opened the floodgates to insurance litigation asserting claims against all participants in the insurance industry is simply not true.[16]

A negligence *per se* cause of action is not the same thing as a common-law bad faith claim, in that it must be tied to at least one of the enumerated prohibited claims settlement practices. The claim merely recognizes a remedy under settled negligence *per se* elements for unfair claims practices that insurance carriers already admit exist and are binding on them. The 14 unfair claims practices are spelled out in ORS 746.230(1):

> "(1) An insurer or other person may not commit or perform any of the following unfair claim settlement practices:

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[16] Based on filings in the Westlaw database, since January 2021, only three complaints have been filed in Oregon courts (one in federal district court and two in Oregon circuit courts) asserting claims for negligence *per se*.

"(a) Misrepresenting facts or policy provisions in settling claims;

"(b) Failing to acknowledge and act promptly upon communications relating to claims;

"(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims;

"(d) Refusing to pay claims without conducting a reasonable investigation based on all available information;

"(e) Failing to affirm or deny coverage of claims within a reasonable time after completed proof of loss statements have been submitted;

"(f) Not attempting, in good faith, to promptly and equitably settle claims in which liability has become reasonably clear;

"(g) Compelling claimants to initiate litigation to recover amounts due by offering substantially less than amounts ultimately recovered in actions brought by such claimants;

"(h) Attempting to settle claims for less than the amount to which a reasonable person would believe a reasonable person was entitled after referring to written or printed advertising material accompanying or made part of an application;

"(i) Attempting to settle claims on the basis of an application altered without notice to or consent of the applicant;

"(j) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the

coverage under which payment has been made;

"(k) Delaying investigation or payment of claims by requiring a claimant or the claimant's physician, naturopathic physician, physician assistant or nurse practitioner to submit a preliminary claim report and then requiring subsequent submission of loss forms when both require essentially the same information;

"(l) Failing to promptly settle claims under one coverage of a policy where liability has become reasonably clear in order to influence settlements under other coverages of the policy;

"(m) Failing to promptly provide the proper explanation of the basis relied on in the insurance policy in relation to the facts or applicable law for the denial of a claim; or

"(n) Any of the practices described in ORS 746.233."

Providing a negligence *per se* cause of action and remedy for carriers' undisputed duties under ORS 746.230 affirms the basic expectations of ordinary insureds—that their own insurers will treat them fairly and reasonably. Furthermore, if insurers are worried about the proliferation of negligence *per se* claims, the solution is in their hands—they can simply handle claims in accordance with the minimum standards established by Oregon law and regulation.

C. Legislative Intent Associated With the UCSP Act Is Not Relevant—But if It Were, the Court Should Take a Broad View

The insurance industry *amicus* briefs make much of the supposed legislative intent not to permit a private cause of action under the UCSP Act. That intent is not relevant to the common-law legal issue before this Court. But even if it were, UP would encourage the Court to take a broader view of legislative intent.

As stated by Oregon Representatives after the Oregon Senate passed SB 414A:

> "'Middle-class families and small businesses need more avenues to hold insurance companies accountable for their harmful violations of consumer protection laws,' said Senator Chip Shields (D-Portland), chair of the Senate Committee on General Government, Consumer and Small Business Protection. * * * 'Oregonians who play by the rules deserve fairness from their insurance companies. Insurers that break the law and cheat consumers need to be held accountable,' said Senate Majority Leader Diane Rosenbaum (D-Portland). SB 414A allows consumers to seek justice when they are hurt as a result of bad actions by an insurance company by ensuring that Oregonians receive the insurance coverage to which they are entitled."[17]

As explained above, while well intentioned, SB 414A clearly did

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[17] Oregon Legislative News Release, 8/20/2013, *available at* https://www.oregonlegislature.gov/senatedemocrats/Documents/sdo_061913.pdf (last visited Sept 14 2022).

not achieve the results intended by the Oregon legislature. Therefore, even if "legislative intent" were relevant to this Court's consideration of whether to allow a claim for negligence *per se,* that intent needs to be considered as a whole including more recent legislative efforts that have clearly not fixed the problem.

D. Oregon is An Outlier—Most States Permit Bad Faith Causes of Action

1. Most States Permit Bad Faith Claims Against First Party Insurers

Every state, including Oregon, recognizes that an insured can sue an insurance company for breach of contract—failing to pay what is owed under the insurance policy.[18] A minority of jurisdictions, however, stop there, and allow only contract damages, not allowing policyholders to recover consequential or extra-contractual damages, such as loss of business opportunity, damage to professional reputation, and emotional distress damages, in an action involving a first-party property policy.

Oregon is one of those minority states. Oregon stands (almost)

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[18] United Policyholders, *50 State Survey of Bad Faith Laws and Remedies* (Oct. 23, 2014), *available at* https://uphelp.org/wp-content/uploads/2020/11/Final-Bad-Faith-Survey.pdf (last visited Sept 14, 2022).

alone in preventing consumers and businesses from fully recovering their damages from an insurer that has acted in bad faith. This puts Oregon homeowners at a disadvantage when trying to get attention paid to their claims from adjusters who are working in multiple states (as most do). It also puts Oregon businesses at a competitive disadvantage. Businesses to the north, south, and east have a key tool—bad faith claims—to get insurers to pay claims promptly and in full, Oregon businesses do not.[19]

The following states are among the majority that recognize a common-law cause of action for bad faith against a first-party insurer:[20]

- **Arizona.** Arizona recognizes a cause of action for bad faith against a first-party insurer. *Noble v. Nat'l Am. Life Ins. Co.*, 624 P2d 866, 868 (Ariz 1981). Consequential, emotional distress, and punitive damages are recoverable. *Farr v.*

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[19] For additional background on the impact a lack of effective remedies can have on consumers, *see* Letter to Hon. Leroy G. Comrie, Jr., May 16, 2019, in support of Bill S5336/A2822-2019 (New York), available at https://uphelp.org/wp-content/uploads/2020/10/up_support_letter_for_2019_ny_fair_ins_practices_bill_final.pdf (last visited Sept 14, 2022).

[20] UP Fifty State Survey, *supra.* note 15 Ca.

Transamerica Occidental Life Ins. Co. of California, 699 P2d 376, 382-3 (Ariz Ct App 1984); *Rawlings v. Apocada*, 726 P2d 565 (Ariz 1986).

- **California.** California recognizes a common law cause of action for bad faith against a first-party insurer. *Gruenberg v. Aetna Ins. Co.*, 510 P2d 1032 (Cal 1973); *Egan v. Mutual of Omaha Ins. Co.*, 598 P2d 452 (Cal 1979) (insurer also commits bad faith by failing to promptly investigate a claim). Emotional distress damages are recoverable. *Cates Const., Inc. v. Talbot Partners*, 21 Cal 4th 28, 43-44 (1999); Cal Civ Code § 3333. An insured may also recover attorney fees incurred in prosecuting a bad faith claim to avoid diminishing any contract recovery. *See Brandt v. Superior Court*, 37 Cal 3d 813 (1985).
- **Hawaii.** Hawaii recognizes a cause of action for bad faith against a first-party insurer. *Best Place, Inc. v. Penn Am. Ins. Co.*, 920 P2d 334 (Haw. 1996). Consequential, emotional distress, and punitive damages are recoverable. *See Best Place*, 920 P2d at 346; *Young v. Allstate Ins., Co.*, 119 Haw 403, 406, 198 P3d 666, 669 (2008).
- **Idaho.** Idaho recognizes a cause of action for bad faith against

a first-party insurer. *See, e.g.*, *White v. Unigard*, 730 P2d 1014, 1021 (Idaho 1986). Consequential, emotional distress, and punitive damages are recoverable. *White*, 730 P2d 1014; *Walston v. Monumental Life Ins. Co.*, 129 Idaho 211, 923 P2d 456 (1996); *Weinstein v. Prudential Prop. & Cas. Ins. Co.*, 233 P3d 1221, 1254-55 (Idaho 2010), *reh'g denied* (July 1, 2010) (citing Idaho Code § 6-1604(1)).

- **Iowa.** Iowa recognizes a common-law cause of action for bad faith against a first-party insurer. *Dolan v. Aid Ins. Co.*, 431 NW2d 790 (Iowa 1988). Consequential, emotional distress, and punitive damages are recoverable. *Nassen v. Nat'l States Ins. Co.*, 494 NW2d 231 (Iowa 1992); *Dolan*, 431 NW2d at 794.
- **Kentucky.** Kentucky recognizes a common-law cause of action for bad faith against a first-party insurer. *Curry v. Fireman's Fund Ins. Co.*, 784 SW2d 176 (Ky. 1989). Consequential, emotional distress, and punitive damages are recoverable. *Curry*, 784 SW2d 176; *Whittmer v. Jones*, 864 SW2d 885, 889 (Ky 1993); *Fed. Kemper Ins. Co. v. Hornback*, 711 SW2d 844, 848 (Ky 1986).

- **Massachusetts.** Massachusetts recognizes a common-law cause of action for bad faith against a first-party insurer. *See, e.g.*, *Green v. Blue Cross and Blue Shield*, 713 NE2d 992 (Mass App Ct). An insured may also bring a collateral action against an insurer for unfair or deceptive business practices. Mass Gen Laws, ch 93A and ch 176D. Consequential, emotional distress, and punitive damages are recoverable. *DiMarzo v. Am. Mut. Ins. Co.*, 449 NE2d 1189, 1200 (Mass 1983); *Hershenow v. Enter. Rent-A-Car Co.*, 840 NE2d 526, 533 (Mass 2006) (citing *Haddad v. Gonzalez*, 576 NE2d 658 (Mass 1991) (following 1979 amendment to GL c 93A § 9); Massachusetts Consumer Protection Act, General Law, GL c 93A, § 9(3).
- **Mississippi.** Mississippi also recognizes an independent common-law cause of action for bad faith against a first-party insurer. *See, e.g.*, *Vaughn v. Monticello Ins. Co.*, 838 So 2d 983 (Miss Ct App 2001). Consequential, emotional distress, and punitive damages are recoverable. *Broussard v. State Farm Fire & Cas. Co.*, 523 F3d 618, 628 (5th Cir 2008); *Jones v. Benefit Trust Life Ins. Co.*, 800 F2d 1397, 1491 (5th Cir 1986); *Vaughn*, 838 So 2d at 988.

The reasons that these states have approved causes of action for bad faith were summed up by UP's 2014 survey of bad-faith laws as follows:

> "The perennial conflict between insurers' profit motives and interests of their insureds has heightened significantly since the 1990s. Court records, media coverage, and consumer responses to surveys conducted by United Policyholders (UP) indicate that insureds are frequently compelled to file suit to collect policy benefits owing and to secure full and fair compensation for losses caused by insurer misconduct. A consumer's ability to hold an insurance company legally and financially accountable for failing to pay what it owes promptly and fairly, is a critically important safeguard in the profit-driven but essential modern insurance system. It also is important to insurers because the threat of damages for violation of claim practices standards should lead them to improve their performance."[21]

All of these things are as true now as they were in 2014, and are just as true about the needs of Oregon consumers and businesses as they are about the consumers and businesses of every other state.

While Oregon's motto is "[s]he flies with her own wings," there is no good reason for Oregon to remain in the minority of states that do not allow recovery of extra-contractual damages from first-party

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[21] United Policyholders, *50 State Survey of Bad Faith Laws and Remedies* (Oct. 23, 2014), https://uphelp.org/wp-content/uploads/2020/11/Final-Bad-Faith-Survey.pdf.

insurers. Oregon should avoid veering off the proper course, follow the majority of states, and *at the least* recognize the independent common-law cause of action for negligence *per se* asserted by Ms. Moody in this case.

2. The Insurance Industry Trades in Myth—There is No Demonstrable Correlation Between Allowing Bad Faith Claims and Increased Premiums

Although *Amici* Chamber of Commerce USA and Oregon Business Industry Association advance a slippery-slope fallacy that allowing negligence *per se* claims will adversely affect Oregon consumers, the facts do not support their "sky is falling" hyperbole.

For example, *Amici* point to a RAND study[22] purportedly demonstrating a 19 percent rise in premiums after a 1979 California court ruling permitted a private right of action for bad faith and punitive damages against an insurer, the case is clearly inapposite. A close look reveals that the claims addressed in the RAND study were "direct-action" bad faith claims for third-party bodily injury arising

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[22] *See* Angela Hawken, et al., *The Effects of Third-Party Bad Faith Doctrine on Automobile Insurance Costs and Compensation (RAND Institute for Civil Justice 2001), available at* https://www.rand.org/pubs/research_briefs/RB9036.html *(last visited August 23, 2022).*

in the auto insurance context. The direct-action bad faith claims referred to in the RAND study, which were permitted in California only until the California Supreme Court reversed course 10 years later, allowed an accident victim injured by a policyholder to bring a lawsuit directly against the policyholder's insurer.

Direct action claims, which are allowed in a very small minority of states, are markedly distinct from the first-party negligence *per se* claim pursued by Ms. Moody. The concern with allowing direct action claims by a claimant victim against a tortfeasor's insurer is the likelihood that insurers will increase settlement offers to bodily injury victims to avoid lawsuits, including punitive damages claims, by those victims. This concern is not present in a first-party claim, where the insured is seeking to recover benefits arising from damage to its own property under its own insurance policy. In short, the RAND study has no relevance to the potential impact of permitting a first-party negligence *per se* claim under Oregon law.

If, as *Amici* claim, the mere existence of bad faith remedies actually led to insurance premium increases, or increases in insurance claims, one would expect Washington state to have experienced dramatic premium increases and increases in insurance

claims after the 2007 passage of the Insurance Fair Conduct Act ("IFCA"), which created a statutory cause of action for insurer bad faith *including treble damages*. *See* RCW 48.01.030 (public interest); RCW 48.030.010 (unfair practices in general—remedies and penalties). The damages authorized under Washington law are exactly the kind of remedies that, per the insurance industry's logic, should "inevitably" lead to higher premiums and an increase in (presumably fraudulent) insurance claims. But the evidence shows that neither one happened after IFCA was enacted in 2007. As shown in a report generated by the Washington Office of the Insurance Commissioner, attached as Appendix B, "Direct Losses" in Washington in 2008 outperformed the national trend in the sectors affected by IFCA.[23]

And while reported average insurance premium rates in Oregon are nominally lower than those in Washington, Washington's premiums are lower than those in many other states that do not have Washington's robust common-law and statutory bad faith

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[23] The term "R-67" used in the presentation refers to Referendum 67, in which Washington voters approved IFCA. *See* https://www.ifcaresources.com/legislative-history (last visited Sept 14 2022).

remedies.[24] If (as Amici posit) bad faith claims inexorably lead to higher premiums, that should definitely not be the case.

The truth, of course, is that average insurance premiums rise or fall for many reasons including weather events, demographics, global economic forces, and supply chain issues. There is no sound public policy reason to deny Oregon policyholders an important, but limited, remedy that is recognized in the majority of states as a normal method of holding insurers accountable based on hyperbolic and counter-factual conjecture from the industry about the impact on premiums or insurance availability.

3. The Insurance Industry Continues to Be Enormously Profitable, Despite the Widespread Availability of Bad Faith Claims

The insurance industry is a global financial force that makes money by investing consumer premiums, with highly sophisticated means for reallocating risk.[25] There is no reason for the insurance

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[24] *See* https://www.bankrate.com/insurance/homeowners-insurance/states/ (comparing premiums on $250,000 in dwelling coverage across the states, with Oregon quoted at $704 annually, Washington priced at $899, and Oklahoma topping out at $3593).

[25] *See* J. Robert Hunter, *The Insurance Industry's Incredible Disappearing Weather Catastrophe Risk: How Insurers have Shifted Risk and Costs Associated with Weather Catastrophes to Consumers And Taxpayers* (Consumer Federation of America, Feb.

industry to be treated differently from others for purposes of negligence *per se*, or any other common law or statutory remedy.

In fact, although insurance companies faced with record-breaking claims are quick to broadcast fears of bankruptcy if they are forced to cover them, nothing could be further from the truth. The industry made similar assertions 30 years ago after the environmental statute CERCLA was passed, claiming that the cost of environmental clean-ups required by CERCLA would be ruinous.[26] Although insurers did ultimately pay CERCLA claims—many only after protracted insurance coverage litigation—the predicted insurance industry collapse never materialized.

17, 2012), https://consumerfed.org/pdfs/InsuranceRegulationHurricaneRiskDisappearingCoverageStudy2-12.pdf), at 1 ("industry data demonstrates that insurers have significantly and methodically decreased their financial responsibility for [catastrophic] events in recent years and shifted much of this risk to consumers and taxpayers. . . . most of these savings have been achieved by hollowing out the coverage in homeowners insurance policies and raising rates").

[26] *See Insurer Liability for Cleanup Costs of Hazardous Waste Sites*, No. 101-175 (101st Cong., 2d Sess., Sept. 27, 1990) (Committee on Banking, Finance, and Urban Affairs), at 18-29 and 75-76.

More recently, in response to the COVID-19 pandemic, insurance companies began "crying wolf" yet again.[27] In actuality, the pandemic has proved exponentially *profitable* for insurance companies—one of the few industries able to make such a claim. In July 2020, Progressive Insurance Company "boasted about an 83% year over year increase in net income" which works out to about $800 million per quarter.[28] Chubb Limited reported net income of $1.19 billion in its third quarter, in 2020—up 9.4 percent, or $100 million, from the year before.[29] CNA Insurance similarly reported a $106 million increase in net income in the same period.[30] W.R. Berkley

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[27] *See, e.g.*, Eli Flesch, *Trade Group Tells 1st Cir. Eateries Not Owed Virus Coverage*, Law360.com (Sept. 15, 2021), https://www.law360.com/insuranceauthority/property/articles/1422231/trade-group-tells-1st-circ-eateries-not-owedvirus-coverage.

[28] Richard Holober, *Progressive Insurance Hoards Covid-19 Windfall Profits*, Consumer Federation of California (Aug. 13, 2020), https://uphelp.org/wpcontent/uploads/2021/02/cfc_progressive.pdf.

[29] Claire Wilkinson, *Chubb reports gains in Q3 profit, net premium written*, Business Insurance (Oct. 28, 2020), https://www.businessinsurance.com/article/20201028/NEWS06/912337411/Chubb-reports-gains-in-Q3-profit,-netpremium-written.

[30] Angela Childers, *CNA Reports Higher Net Income Despite Cat Losses*, Business Insurance (Nov. 2, 2020), https://www.businessinsurance.com/article/20201102/NEWS06/912337508/CNA-reports-higher-net-income-despite-cat-losses.

Corporation reported a massive 161 percent increase in its fourth quarter, in 2020.[31]

Moreover, insurance companies significantly *increased* their rates starting in 2020 across all lines of business. One large broker reported that 89 percent of its clients saw a rate increase for their property insurance—the "highest number recorded since the early 2000s."[32] From April through June 2020, property insurance rates spiked by 22 percent.[33] Insurance companies ratcheted up prices again between July and September, with a total increase of 24 percent for commercial property coverage.[34] From October to

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[31] J. Greenwald, *Berkley Reports 161% Jump in Profits*, Business Insurance (Jan. 26, 2021), *available at* https://www.businessinsurance.com/article/00010101/NEWS06/912339367/Berkley-reports-161-jump-in-profits.

[32] Matthew Lerner, *Most Policyholders See Rate Hikes Across Multiple Lines*, Business Insurance (Oct. 26, 2020), https://www.businessinsurance.com/article/20201026/NEWS06/912337341/Most-policyholders-see-rates-hikes-acrossmultiple-lines-Arthur-J-Gallagher-Re.

[33] Matthew Lerner, *U.S. Commercial Property Pricing up 22% in Q2*, Business Insurance (Aug. 10, 2020), https://www.businessinsurance.com/article/NEWS06/912336034/US-commercial-property-pricing-up-22-in-Q2.

[34] Claire Wilkinson, *Insurance Prices Increased Sharply in Third Quarter*, Business Insurance (Nov. 5, 2020), https://www.businessinsurance.com/article/00010101/NEWS06/912337590/Insurance-prices-increased-sharply-in-thirdquarter-Marsh.

December 2020, premiums increased another 20 percent.[35] In late 2020, property insurance companies told consumers to expect increases of 15 percent to 25 percent in 2021.[36] Any assertion that the insurance industry will be prejudiced by being held to its good faith obligations should be viewed with extreme skepticism. The insurance industry should not be exempt from the same common law duties as any other.

E. Oregon Businesses and Consumers Must Rely on Their Insurers in Times of Crisis, Justifying the Holding Insurers Minimally Responsible for Claims Handling Violations

Below and on review, insurers and Amici argue that in *Georgetown Realty v. The Home Ins. Co.*, 313 Or 97, 110-11, 831 P2d 7 (1992), "[t]his court held that where a liability insurer undertakes to defend its insured, it results in the 'kind of relationship [that] carries with it a standard of care that exists independent of the

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[35] Matthew Lerner, *Global Prices Rise 22% in Q4: Marsh*, Business Insurance (Feb. 4, 2021), https://www.businessinsurance.com/article/20210204/%20NEWS06/912339588/Global-prices-rise-22-in-Q4-Marsh-Global-InsuranceMarket-Index-.

[36] Judy Greenwald, *Continued Rate Increases Expected: Willis*, BUSINESS INSURANCE (Nov. 19, 2020), https://www.businessinsurance.com/article/20201119/NEWS06/912337904/Continued-rate-increases-expected-WillisTowers-Watson.

contract and without reference to the specific terms of the contract." Petitioner on Review Federal Insurance Company's Brief on the Merits and Excerpt of Record, at 15.

In *Georgetown Realty*, this Court held that an insurer could be held liable to the insured for a breach of duty that was independent of the terms of an insurance policy, where the insurer agreed to provide legal representation to and stand in the shoes of the insured. The Court held that, under those circumstances, the insured had relinquished control over the defense of the claim asserted against it and had entrusted its potential liability to the insurer. Thus, it followed that the insurer was required to act in the best interests of the insured in defending the claim. 313 Or at 110-11.

To the extent that *Georgetown Realty* and related cases have been read to limit the circumstances in which an insurer can be found to be in a special relationship to the duty-to-defend context, that interpretation is incorrect. In *Conway v. Pacific University*, 324 Or 231, 240-41, 924 P2d 818 (1996), the Court explained the nature of "special relationships":

> "Another way to characterize the types of relationships in which a heightened duty of care exists is that the party who owes the duty has a *special responsibility* toward the

> other party. This is so because the party who is owed the duty effectively has authorized the party who owes the duty to exercise independent judgment in the former party's behalf and in the former party's interests. In doing so, the party who is owed the duty is placed in a position of reliance upon the party who owes the duty; that is, because the former has given responsibility and control over the situation at issue to the latter, the former has a right to rely upon the latter to achieve a desired outcome or resolution.
>
> "This special responsibility exists in situations in which one party has hired the other in a professional capacity, as well as in principal-agent and other similar relationships. It also exists in the type of situation described in *Georgetown Realty*, in which one party has relinquished control over the subject matter of the relationship to the other party and has placed its potential monetary liability in the other's hands. In all those relationships, one party has authorized the other to exercise independent judgment in his or her behalf and, consequently, the party who owes the duty has a special responsibility to administer, oversee, or otherwise take care of certain affairs belonging to the other party. That special responsibility carries with it a duty to exercise reasonable care to avoid making negligent misrepresentations." (Emphasis in original.)

See also Loosli v. City of Salem, 215 Or App 502, 510, 170 P3d 1084 (2007), *aff'd*, 345 Or 303, 193 P3d 623 (2008) ("Second, not unlike the circumstances in *Conway*, the city here had no *heightened* responsibility to act for the benefit of plaintiffs in administering, overseeing, or otherwise taking care of plaintiffs' application.") (emphasis in original).

The above examples of homeowners that have suffered abuses during adjustment of first-party claims make it clear that *Conway's* conception of a "special relationship" can and should apply in the first-party context. In other words, a special or heightened responsibility to act for the benefit of an insured does arise in the first-party claims handling context, including administering, communicating about, investigating, settling, or taking care of a claim.

In the first-party claims handling process, the insured is relying on the greater expertise, and control exercised by, the insurer in a way that is not significantly different than an insured that is being defended by its insurer. This is particularly true because insurance policies are not like other contracts: unlike other contracts, an individual cannot "cure" or "cover"—the insured cannot simply go out in the marketplace and get another insurance policy for the same thing (like widgets). As explained by the Delaware Supreme Court:

> "Insurance is different. Once an insured files a claim, the insurer has a strong incentive to conserve its financial resources balanced against the effect on its reputation of a 'hard-ball' approach. Insurance contracts are also unique in another respect. Unlike other contracts, the insured has no ability to 'cover' if the insurer refuses without justification to pay a claim. Insurance contracts are like

> many other contracts in that one party (the insured) renders performance first (by paying premiums) and then awaits the counter-performance in the event of a claim. Insurance is different, however, if the insurer breaches by refusing to render the counter-performance. In a typical contract, the non-breaching party can replace the performance of the breaching party by paying the then-prevailing market price for the counter-performance. With insurance this is simply not possible. This feature of insurance contracts distinguishes them from other contracts and justifies the availability of punitive damages for breach in limited circumstances."

E.I. DuPont de Nemours & Co. v. Pressman, 679 A2d 436, 447 (Del 1996) (internal citations omitted).

It is impossible to obtain insurance for something that has already happened (e.g., a car accident or a fire). Once a claim arises, for better or for worse, the insurer and the insured are stuck with each other and the insurance policy in place at the time the claim arose. The insured is therefore at the mercy of the insurer's claims process. And even if the insurer is in gross breach of contract, the insured is trapped in a claims process completely controlled by the insurer.

It is important to remember that insurance policies cover *losses*, including personal losses of cherished loved ones and decades-long life partners. This means insurers are generally dealing with

claimants at their most vulnerable, weakest moments in their lives. The claimants may be reeling from a financial, emotional, or physical catastrophe while the insurer is coming from a position of strength, armed with a harsh, unsympathetic claims process. The power imbalance is particularly acute during the claim adjustment process because of this.[37] This is why consumers need and deserve methods—both statutory and through the common law—to hold insurers accountable.

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[37] Courts have recognized the need for tort remedies to deter misconduct in analogous situations. *See, e.g.*, Robert A. Brazener, *Civil liability of undertaker in connection with embalming or preparation of body for burial*, 48 A.L.R.3d 261 (Originally published in 1973) ("Recognizing the bereavement of relatives of the deceased during the period in which the arrangement and accomplishment of burial takes place, the common law has developed the general rule that any unwarranted interference with the right to burial constitutes an actionable wrong.").

IV. CONCLUSION

For the reasons stated above and in Ms. Moody's Answering Brief, this Court should affirm the decision of the Oregon Court of Appeals and recognize an independent common-law cause of action for negligence *per se* including against a first-party insurer.

DATED this 15th day of September, 2022.

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DATED: September 15, 2022.

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United Policyholders™
www.uphelp.org

For immediate release: September 13, 2022

For information contact: Amy Bach, 415-713-3048

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.

   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.

   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.

The Effects of Good Faith Legislation (R-67)

Claims versus Realities

The Opponent's Claims

- "Milliman found when states altered bad faith laws insurance premiums increased 3.5 to 7 percent more than the national average."
- "Assuming the national average for insurance premium increases is 5 percent the (Milliman) study predicts Washington's premiums could increase up to 12 percent, costing Washington consumers $650 million annually."
- "(R-67) applies to claims related to homeowner's insurance, auto insurance, long-term care insurance, property insurance, malpractice insurance and small business insurance."

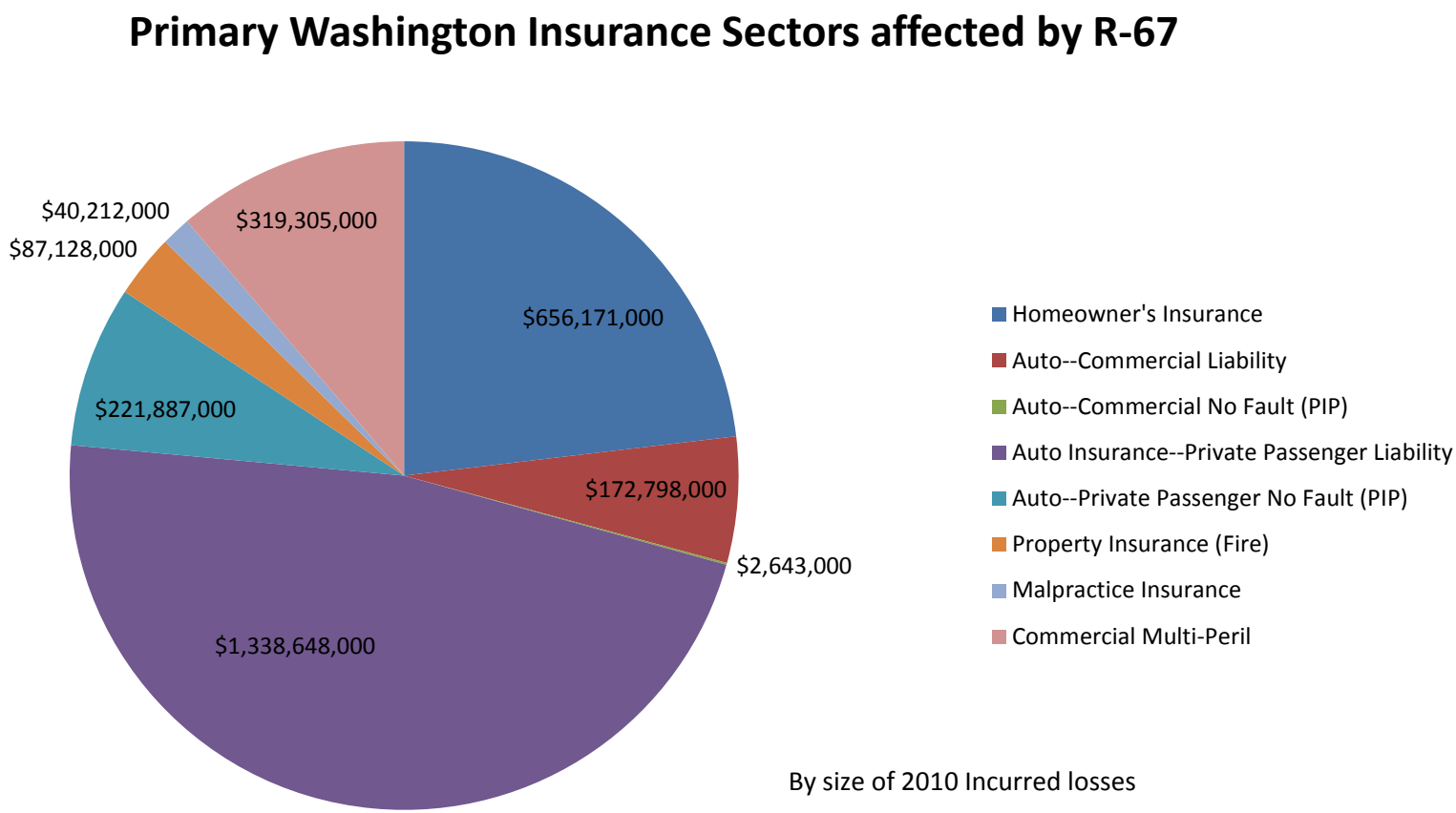
Washington Research Council
Policy Brief
October 22,2007

Post Election Claims

- “Excess UM (uninsured motorist) loss costs attributable to R-67 may have totaled as much as $17.4 million during the first two years following enactment."
- "...an additional $190 million in homeowner’s coverage loss costs—approximately $50 per insured home— in the first two years of R-67."

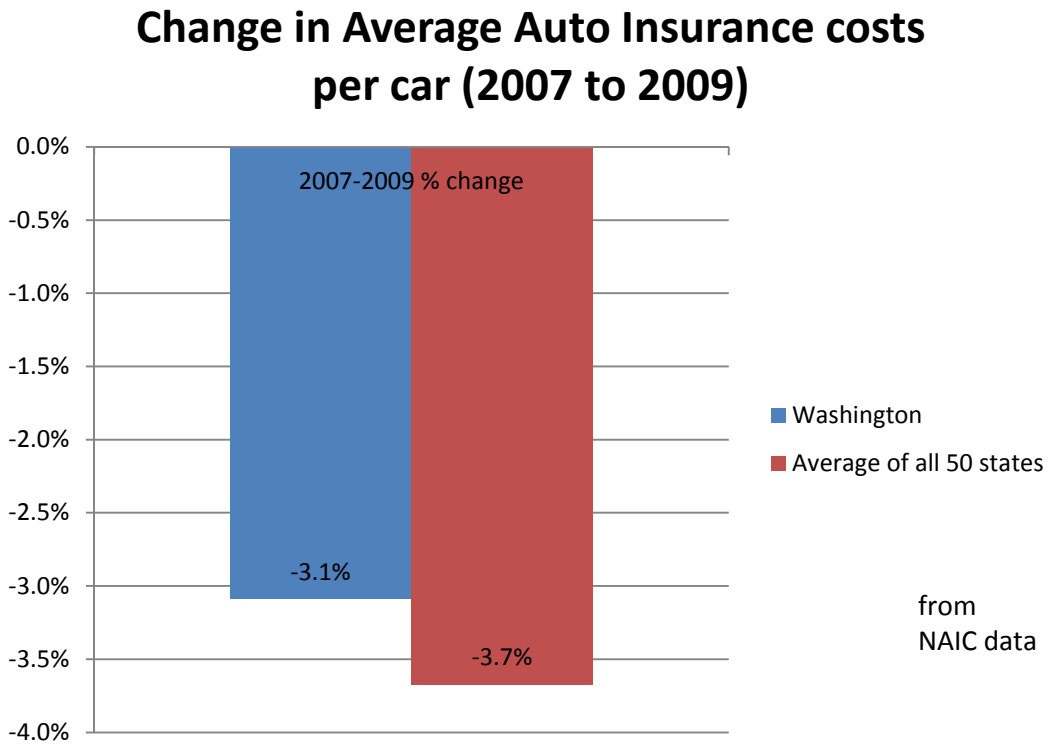
From “The Impact of First-Party Bad-Faith Legislation on Key Insurance Claim Trends in Washington State” -- Insurance Research Council (February 2011)

A little background



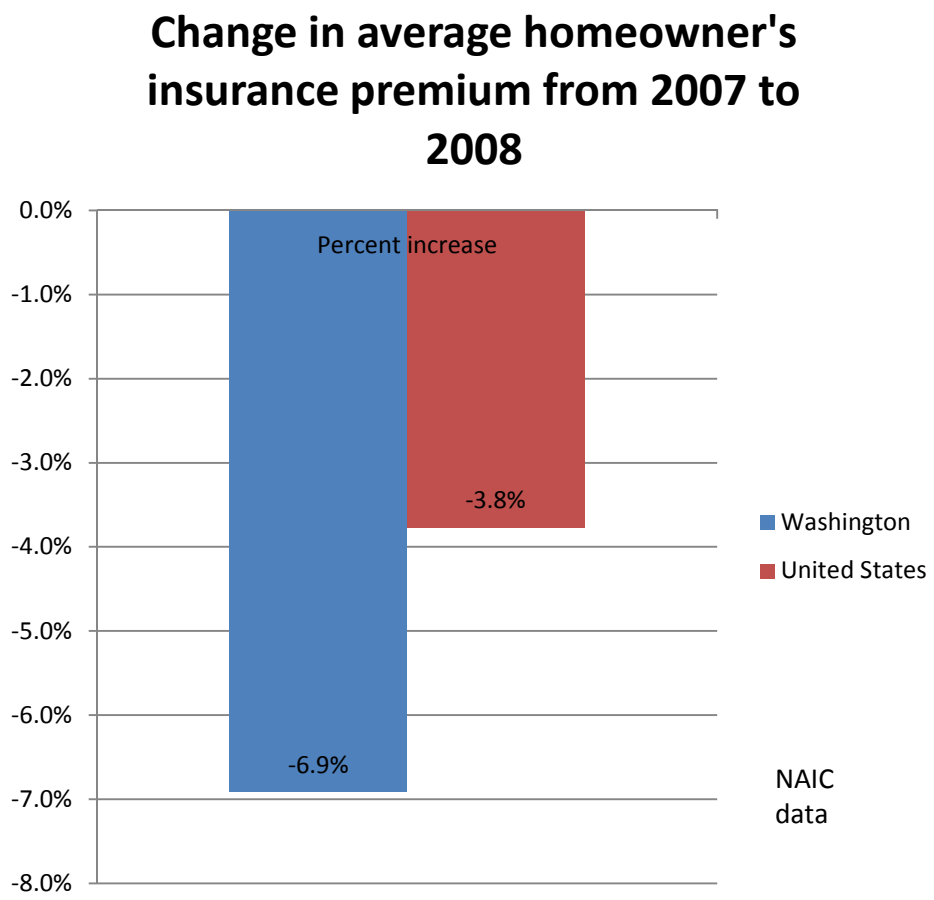
Early Indicators

- Auto

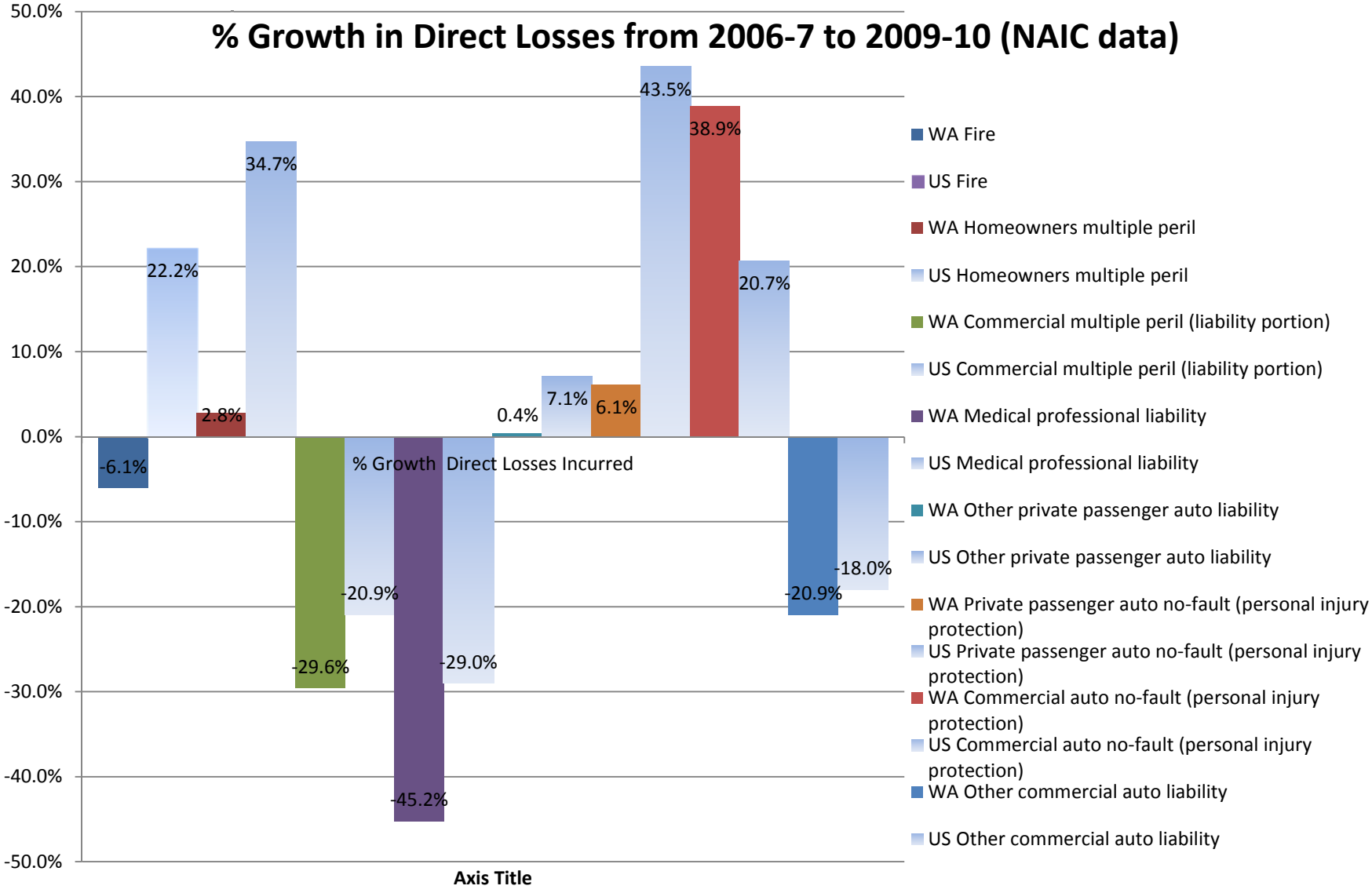


Early Indicators

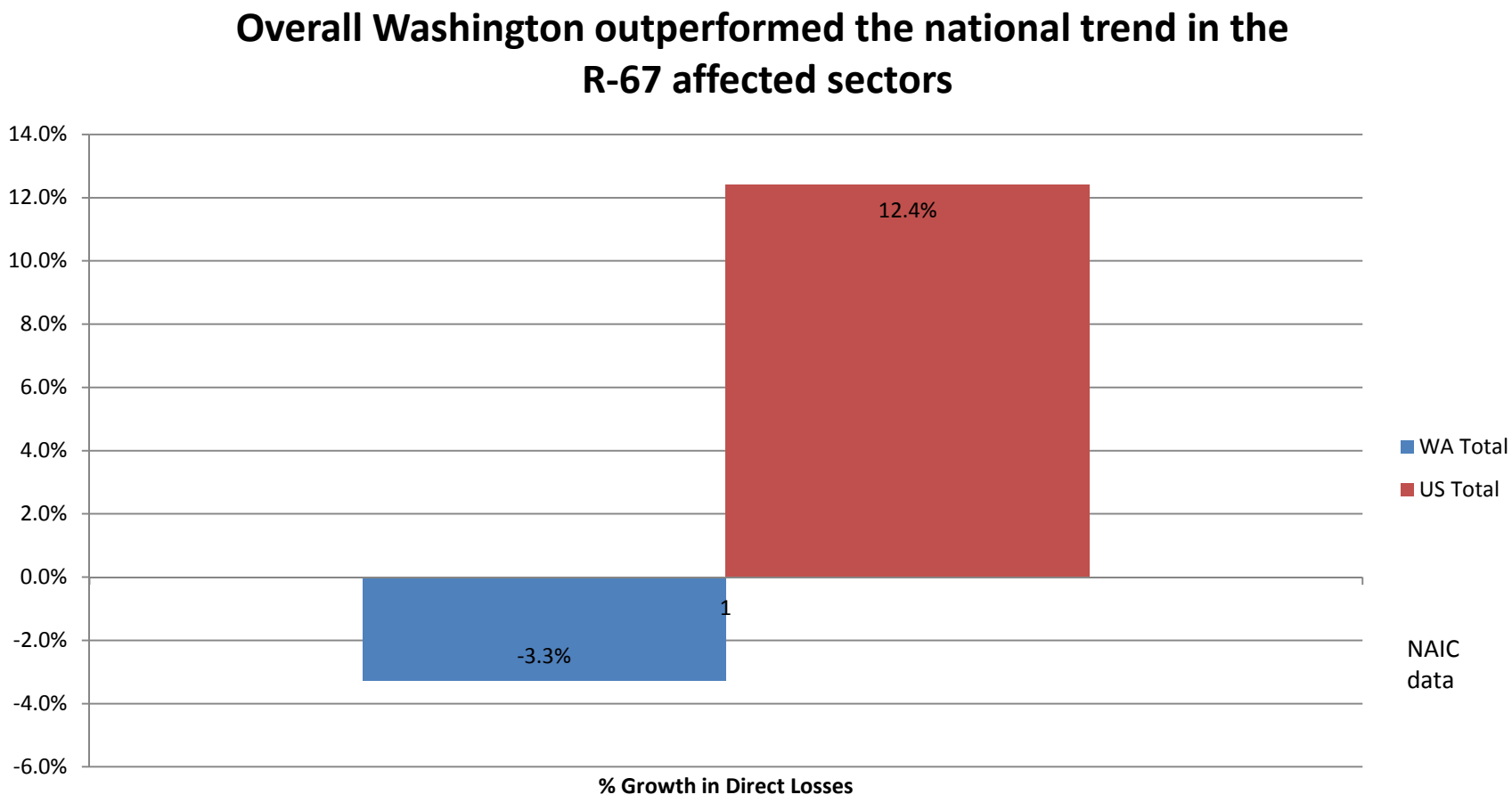
- Homeowner's Insurance



Realities—data to 2010



Conclusion


Overall Washington outperformed the national trend in the R-67 affected sectors
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
-2.0%
-4.0%
-6.0%
12.4%
-3.3%
1
% Growth in Direct Losses
WA Total
US Total
NAIC data